REPORT DOCUMENTATION PAGE

Form Approved
OMB No 0704-0188

REPORT DATE	3. REPORT TYPE AND DATES COVERED
	THESIS/[illegible]

4. TITLE AND SUBTITLE
Near-Death Experiences: An Exploration of Perceived Responses, Effects of Interventions, and Impact

5. FUNDING NUMBERS

6. AUTHOR(S)
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7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
AFIT Student Attending: University of Arizona

8. PERFORMING ORGANIZATION REPORT NUMBER
AFIT/CI/CIA-91-080

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
AFIT/CI
Wright-Patterson AFB OH 45433-6583

10. SPONSORING / MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for Public Release IAW 190-1
Distributed Unlimited
ERNEST A. HAYGOOD, Captain, USAF
Executive Officer

12b. DISTRIBUTION CODE

13. ABSTRACT (Maximum 200 words)

14. SUBJECT TERMS	15. NUMBER OF PAGES 176
	16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT	18. SECURITY CLASSIFICATION OF THIS PAGE	19. SECURITY CLASSIFICATION OF ABSTRACT	20. LIMITATION OF ABSTRACT

ABSTRACT

This study explored near-death experience (NDE) survivors' perceptions and communication in the disclosure of NDEs to health care professionals and significant others, interventions encountered, and effects of those actions. Eight adult NDErs, selected through network sampling, were interviewed. Their NDEs had occurred during diverse circumstances including near-drowning, miscarriage, routine surgery, drug overdose, cardiac arrest, and a motor vehicle accident. Content analysis was used to describe the interactions from the experients' perspective.

A dynamic communication process emerged as central to disclosure about NDEs. Study subjects identified several barriers to disclosure. Actions that were most helpful included listening, showing interest, offering opportunities for disclosure, and providing information and confirmation. Negative actions and their impacts included ignoring or refusal to listen, minimizing the experience, discounting, and medicating the person. Health care professionals were perceived to lack knowledge of the phenomenon and to appear afraid, disinterested, or too busy to talk. All experients conveyed a need to talk about the NDE. Implications for nursing practice include widespread dissemination of information about NDEs and maximizing communication skills to meet NDE patients' needs. Further research related to NDEs and is recommended.

Title: Near-Death Experiences: An Exploration of Perceived Responses, Effects of Interventions, and Impact

Pages: 176

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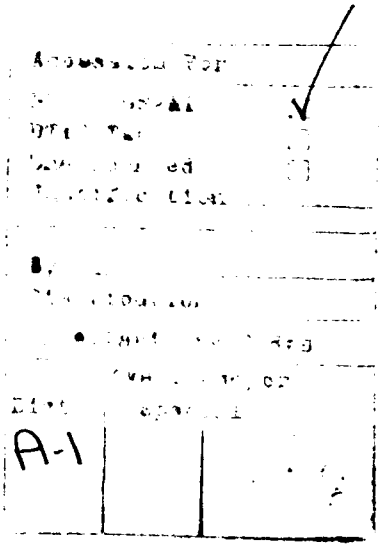

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NEAR-DEATH EXPERIENCES: AN EXPLORATION OF PERCEIVED RESPONSES, EFFECTS OF INTERVENTIONS, AND IMPACT

by

LaVon Eileen Yuill

A Thesis Submitted to the Faculty of the

COLLEGE OF NURSING

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF SCIENCE

In the Graduate College

THE UNIVERSITY OF ARIZONA

1 9 9 1

STATEMENT BY AUTHOR

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8/22/91
Date

ACKNOWLEDGEMENTS

I wish to express my profound appreciation and sincere gratitude to those who were instrumental in the completion of this thesis. To Linda Phillips, Chairperson, for her keen insight and invaluable guidance, for the remarkably expedient chapter reviews, and for her calm reassurance in overcoming problems and time constraints. To Leanna Crosby for her steadfast belief in me, for urging me to strive toward a challenging endeavor, and for her support and sage advice as I waded through the process. To Judy Ayoub, who's boundless enthusiasm and encouragement were my mainstay and who was pivotal in facilitating this thesis by making it possible to find study subjects. I feel fortunate to have had such an esteemed thesis committee.

To my family for their love, support, and unwavering confidence in me. To my mother, who nurtured my spiritual faith and encouraged me to be bold and strong in that faith to accomplish this thesis. To my father whose advice has guided me in my nursing career and who, by chance, introduced me to Dr Moody's book Life After Life, which blossomed into this study.

My deepest gratitude to the study participants who so generously shared their feelings and experiences as near-death survivors. To these courageous men and women, this thesis is dedicated to you.

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ABSTRACT

This study explored near-death experience (NDE) survivors' perceptions and communication in the disclosure of NDEs to health care professionals and significant others, interventions encountered, and effects of those actions. Eight adult NDErs, selected through network sampling, were interviewed. Content analysis was used to describe the interactions from the experients' perspective.

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CHAPTER ONE

INTRODUCTION

Patients revived from the brink of death sometimes report experiencing unusual phenomena which they believe occurred while they were "actually dead". This study was designed to investigate disclosure of these phenomena.

One of life's greatest mysteries is the concern about what happens after life. Is death a black void that marks the end of existence? Or does the soul, which is described by Watson (1989) and Morse (1990) as one's spirit, inner self, mind, or consciousness, survive death and transcend to another dimension beyond earthly life? These questions have perplexed humans through the ages. Philosophers, theologians, and scientists have searched to prove or disprove the existence of a life after death.

The most compelling information about life beyond death comes from those who have been revived when clinically near-death, or in some cases, patients who have spontaneously revived after being pronounced dead (Moody, 1975; Morse, 1990, Ritchie, 1978). Some of these patients report a unique, subjective experience while on the threshold of death. These events, called near-death experiences (NDEs), involve memory of a time the person was unconscious (Morse, Castillo, Venecia, Milstein, & Tyler, 1986). Greyson (1983) indicated that the recollection and recounting of the NDE are profound psychological events for the patient. Dougherty (1990)

described the NDE as a major life transition which significantly impacts on the patient and family. She emphasized the importance for nurses to be open, understanding, and willing to discuss the experience with the patient and family. Dougherty (1990) asserted that the NDE itself should not be interpreted as an abnormal psychiatric process. To imply that the NDE is some sort of psychopathology or to attempt to label the experience in physical or psychological terms (such as an adverse reaction to medication or a stress reaction) can be devastating to the patient (Corcoran, 1990; Serdahely, Drenk, & Serdahely, 1988). The purpose of this study was to explore NDE experients' interactions with others concerning their NDE, and the impact of these interactions and of the NDE itself.

NDEs are defined as profound transcendental events that exist when an individual can recount a separation of consciousness from the physical body while in a state of clinical death (Greyson, 1983; Walker, 1989). They are phenomena which are known to occur to patients during events such as critical injury or trauma (including combat), cardiac arrest, or severe illness (Moody, 1975; Ring, 1980; Sabom, 1982). Children and adults of all ages have reported NDEs (Moody, 1988; Morse, 1990; Ring, 1984). A 1982 Gallup poll estimated that eight million people within the United States have had an NDE (Ring, 1984). Another study indicated that

38% to 50% of all patients who clinically come very near to death from any cause may have an NDE (Corcoran, 1988). A growing number of near-death phenomena has been reported as the result of increased technology, rapid emergency responses with sophisticated prehospital care, and highly effective resuscitative measures in emergency or special intensive care units (Oakes, 1981; Walker & Serdahely, 1990).

There is a consistent pattern to NDEs regardless of culture, religion, race, gender, age, or precipitating cause (Freeman, 1985; Sabom, 1982; Sutherland, 1990). Common features of NDEs include an overwhelming feeling of peace and well-being, a sense that one's consciousness has separated from one's body, a sense of entering a dark tunnel or void, an encounter with a being of light, a panoramic life review, an encounter with others, including living or dead relatives, and a sense of the presence of a deity (Morse et al., 1986; Ring & Franklin, 1981).

The revelations from these phenomena have sparked debate about what causes NDEs, as well as their validity and their implications for life after death. Explanations have included physiological, psychological, and supernatural causes. A discussion of NDEs and their interpretation invariably involves the topics of death and religion or spiritual beliefs. But these subjects evoke deep personal feelings and beliefs and often cause uneasiness (Drake, 1988; Walker &

Serdahely, 1990). They are taboo subjects for most persons of Western cultures (Drake, 1988). Because of their deep personal nature and the social taboos, it is difficult for many people to broach these intimate subjects with others, especially relative strangers as encountered in the health care setting. Additionally, such discussion may force listeners to face their personal feelings about death, dying, and religion (Kubler-Ross, 1969). Listeners may be uneasy about their own vulnerability, or simply feel uncomfortable hearing another's personal experiences. The discomfort elicited about death, dying, and religion is further increased by the fantastic stories of NDE experients who tell of "floating out-of-body", "talking to God", or meeting dead relatives. Extensive research in the past decade has confirmed the existence of the NDE phenomenon (Greyson, 1985; Morse, 1990; Ring, 1980, 1984; Sabom, 1982). Yet some health care professionals do not believe the NDEs to be real experiences because they are intangible and not easily explained or validated by medical science (Dougherty, 1990).

Reactions to such revelations from an NDEr (near-death experiencer) are potentially as diverse as the individuals in whom the experient confides. Patients responses to NDEs range from peace, joy, and wonderment, to anger at returning, depression, fear, uncertainty, and confusion about what has happened (Dougherty, 1990; Morse, 1990; Ring, 1984; Serdahely

et al., 1988). Many patients feel that something very special has happened to them, but they are afraid to share it with family, friends, or health care workers because they fear no one will believe them and are afraid of being ridiculed or labelled "crazy" (Dougherty, 1990; Serdahely et al., 1988). Moody (1988) stated that many NDErs told him that their doctors advised them to ignore their experiences. The majority of NDErs describe it as a profound life-changing event that cannot be forgotten, thus skepticism from others sometimes raises self-doubt and introspection (Moody, 1988; Sabom, 1982). In most cases, NDE experients want validation, assurance, and understanding from the medical profession and significant others (Morse, 1990; Ring, 1984). When this is denied, it may make the person feel isolated and greatly extend the time necessary to assimilate the NDE (Dougherty, 1990; Ring, 1984). Morse (1990) found medical explanations of hallucinations or bad dreams only fostered fear and anxiety in child NDErs and their families. After the NDE phenomenon was explained, it provided comfort to them, and in the case of children who were terminally ill, the NDEs helped to promote love and peace through the dying process and to assuage grief. Although the NDE is a vivid, subjective event, how experients interpret and assimilate it into their lives can be influenced by the responses of health care providers and significant others.

Significance of the Problem

Investigations into NDEs have revealed a wide variety of ways people respond to the report of an NDE. Reactions include total disbelief, fear, dismissal of the NDE as imagination, dreams, or hallucinations, referral for psychiatric care, and sedation, as well as acceptance and support (Moody, 1975, 1977, 1988; Ritchie, 1978; Ring, 1984). Surveys of health care workers show controversy concerning the validity of NDEs as an experience other than a hallucination or dream versus an actual experience that involves life after death (Moody, 1988; Morse, 1990; Walker, 1989). Morse (1990) contended that many health care professionals do not know how to respond to a patient's report of an NDE. He stated training for physicians may involve as little as a single lecture on death and dying. Sabom (1982) also indicated that physicians need to be sensitized to NDEs.

Hayes and Waters (1989) conducted a study to ascertain health care providers' knowledge and attitudes about NDEs, and interventions used for NDE patients. The study included registered nurses, physicians, and clergy. The overall return rate of surveys was 41% with a disproportionate rate among the three groups: 68% for nurses, 17% for physicians, and 35% for clergy. A majority (71%) indicated they were familiar with NDEs. However, scores of "actual" knowledge about NDEs, obtained on open-ended questions about NDE features, were

noticeably low with a mean score of 5 out of a possible 16. The majority of respondents who said they were familiar with NDEs indicated they had first learned about them more than 10 years previously. Death education in general and programs about the near-death experience in particular were not major portions of the health providers' formal education. One fourth of the respondents had no formal coursework in death education. The lay press (newspapers and magazines) was the most prevalent initial source of information, followed by patients who had NDEs (percentages not given). Most respondents listed only one intervention for NDErs, and at least 25% of the respondents were unable to list any interventions. There was a positive correlation between the "actual" knowledge score and the number of interventions identified. More than 75% of the respondents indicated an interest in learning more about NDEs.

In a study of 30 critical care nurses, Oakes (1981) found most nurses thought the NDE phenomena was fascinating, but the gamut of responses included complete disbelief and skepticism. Eighty percent of the respondents stated that a patient's claim of an NDE would not influence the nursing care given. Orne (1986) surveyed 912 nurses from all clinical specialties about their attitudes and beliefs toward NDEs. The majority (70%) claimed they were aware of the phenomenon, but 58% of these respondents subjectively rated their knowledge as

limited or very limited. This knowledge deficit was even more evident in the low scores on the questionnaires, which assessed knowledge of NDE characteristics through multiple choice and open-ended questions. Of the nurses who had stated they were familiar with NDEs, 89% scored only 50% or below. It is noteworthy that nurses who were in fact informed, as judged by the tests, had more positive attitudes towards NDEs. Orne's (1986) study, also found the major sources of information about the NDE were the lay press and media. These studies indicate variations between attitudes and interventions for NDEs and deficits in health care workers actual knowledge of the NDE phenomenon.

NDE researchers found that patients are reluctant to initiate discussion about their NDE but talk more readily when they perceive the caregivers believe their reports and respect their feelings (Oakes, 1981; Sabom, 1982). Health care professionals are encouraged to be open, accepting, and nonjudgmental in their attitudes with patients who may have had an NDE (Corcoran, 1988; Lee, 1978; Trevelyan, 1989; Walker, 1989). Because near-death survivors fear ridicule and being labeled "crazy" they are sensitive to the nonverbal messages as well as verbal cues from the people in whom they attempt to confide (Serdahely et al., 1988). In the studies of health care workers, the majority of respondents indicated a positive attitude toward NDEs though admitted to limited

knowledge of the common characteristics of NDEs (Hayes & Waters, 1989; Walker, 1986). With the limited awareness of the NDE features, it is likely that health care workers may initially react, at the very least, with nonverbal cues of surprise, skepticism, or disbelief at the fantastic revelations of an NDE experient. They may also miss subtle clues when the NDEr attempts to broach the subject to ascertain whether or not it is okay to talk about it. While health care workers may strive to be open and nonjudgmental, it is likely the NDEr's perceptions of this attitude is the deciding factor in whether the patient feels free to disclose such a unique and personal experience.

The NDE is often described by patients as the most profound experience of their lives (Dougherty, 1990; Greyson, 1985; Moody, 1977; Morse, 1990; Noyes, 1980; Ring, 1984). A trusted nurse is usually the first person the patient approaches for help in understanding their NDE and in verifying the events that took place while the patient was having the experience (Oakes, 1981). Patients report NDEs in relation to nearly every nursing specialty including emergency, cardiology, surgery, oncology, maternity, pediatrics, and psychiatry (Morse, 1990; Ring, 1984; Sabom, 1982). Thus, nurses in any area of practice have a tremendous potential to impact positively or negatively on the patient's reaction and adjustment to an NDE.

Morse (1990) found that nurses responded to his work in NDE research with accounts of many similar experiences among their patients, while physicians were less likely to be aware of the phenomena. He suggested that the difference was in how they treated their patients. Morse (1990) felt physicians tended to be more brusque and hurried while nurses spent more time talking and listening to the patients.

One area that Morse (1990) identified as a need for greater application of NDE research was in work with terminally ill patients. He found the NDEs enriched the lives of the patients and their families, gave meaning to the process of living and dying, gave control and dignity to the dying patient, gave peace and comfort to all involved, and helped the healing process.

As technology advances and resuscitative measures become more effective, the number of NDE experients is increasing (Oakes, 1981). Studies show that an overwhelming number of nurses surveyed have limited knowledge of the NDE phenomena, but were interested in learning more about it (Hayes & Waters, 1989; Oakes, 1981; Orne, 1986). Nursing practice must recognize the patient care needs that have arisen concerning NDEs and must implement appropriate interventions into clinical practice. Thus, there is a need for nursing research to investigate NDEs and to explore ways to interact positively with NDE experients and their families.

Conceptual Framework

This thesis was guided by two main concepts, interaction and intervention. Interaction was included because it is a process central to determining the factors that affect NDErs' disclosure of their transcendental experiences. The second concept of the framework, intervention, was explored to develop ways to meet NDE patients' needs and to evaluate the effect of what was actually done.

Interaction

Interaction is a key component in several nursing theories. Interaction models emphasize relationships between people, with perception and communication as major characteristics of the process (Fawcett, 1989). King (1981) defined interaction as "a process of perception and communication between person and environment and between person and person, represented by verbal and nonverbal behaviors that are goal directed" (p. 145). Perception is "each person's representation of reality" while communication is the information component of interactions whereby information is exchanged (King, 1981, p. 146).

King (1981) indicated that each individual in the interaction "brings different knowledge, needs, goals, past experiences, and perceptions, which influence the interactions" (p. 145). Nursing is viewed as an interpersonal process of action, reaction, interaction, and transaction to

meet the needs of the individual (King, 1971). Systematic, purposefully planned interactions between the nurse and the patient lead to transactions and to goal attainment (King, 1986). Orlando's (1961) nursing theory depicts the elements of interaction as the patient's behavior, and the nurse's reactions and actions.

Each individual has a unique influence on each interaction. Person is often described in nursing theories as an integrated whole, composed of physical, psychological, and sociocultural components, continuously interacting with internal and external forces through the life process. Watson (1985) defined the individual as a living, growing gestalt composed of mind, body, and soul. As in King's (1971) model, Watson (1985) asserted that both the nurse and the patient bring their entire selves, along with past experiences, beliefs, values, and attitudes into the interaction.

Interaction is a dynamic, ongoing process in which the nurse and the patient each affect the behavior of the other and both are affected by factors within the situation (King, 1981). Interactions are two-way reciprocal processes characterized by continuous giving and receiving of information and feedback between the nurse and patient (King, 1986). The continuous process of interacting involves both perception and communication.

Perception

A person's perceptions are derived from interactions with others (Fawcett, 1989). Perception is a process of organizing, interpreting, and transforming information from sense data and memory; a process which influences behavior, gives meaning to experience, and represents the individual's image of reality (King, 1981). In King's (1981) model, perception, which influences all behaviors, is universal in that everyone experiences it; is subjective; and is experienced in a unique manner by each individual involved. The perceptions of each person leads to judgments and actions based on the interpretation and value placed on the information (Daubenmire & King, 1973). Knowledge of perception is essential for nurses to understand self and to understand patient needs (King, 1989). Exploration of the patient's perceptions helps nurses to understand the patient's point of view and to facilitate care planning (King, 1989). Explication of perceptions is the vital link between patient and nurse which is necessary for reaction, interaction, and transaction to occur. According to King (1981), perceptual accuracy increases the effectiveness of one's actions. Perception, along with communication, provides a channel for passage of information between individuals (King, 1989).

Communication

Communication is the component by which information is exchanged, directly or indirectly, to bring order and meaning to human interaction (King, 1981). One communicates on the basis of perceptions with persons and environmental factors (King, 1971). According to King (1981), characteristics of communication are that it may be verbal or nonverbal, and that it is situational, perceptual, transactional, irreversible, personal, and dynamic. The exchange of attitudes through verbal and nonverbal cues may or not may not be intentional. Nonverbal behavior, such as facial expressions, body movement, gestures, direction of gaze, and spatial position, is perhaps the most important, accounting for 80% of all communication (Lamar, 1985). Nonverbal cues are judged to be spontaneous and unintentional and may be seen as more accurate than verbal messages (Lamar, 1985). Communication, by all forms, signs, and symbols, is the way in which a person's view of events and situations is made known to others, thus it is an essential factor of interactions (King, 1968).

Interactions were explored in this thesis to determine how, when, and to whom a patient disclosed information about an NDE. Responses are an integral part of the interaction, providing feedback and determining further communication. Reactions may or may not be intentional and since the patient is influenced by all actions or reactions, it is important to

look at the effects of all of them. The NDErs' perceptions of health care professionals' openness and acceptance of the event are a critical part of this concept. It is necessary to determine which specific actions and nonverbal cues promote trust and discussion, and which deter patients from such disclosure.

Intervention

The second concept in this study was intervention. Both King (1981) and Orlando (1961) indicated that the interaction between the patient and the nurse is the assessment phase of the nursing process which allows the nurse to ascertain the patient's needs and then plan appropriate actions based on the patient's needs. The nursing process is then continued through interventions. Intervention refers to the action or actions initiated to accomplish the defined goals and objectives (George, 1990). Implementation is also used to describe this aspect, however the term intervention was used for this thesis. England defined intervention as the giving of deliberate, purposive nursing care or therapy (Fitzpatrick & Whall, 1989). Orlando (1961), along with most nursing theorists, stated that interventions must be evaluated to validate that the patient's needs were actually met. Evaluation of interventions requires an investigation of the actions taken during the interventions and the impact of each action on the patient.

Action

King (1981) defined action as a sequence of behaviors involving both mental and physical activity. First there is mental action to recognize the presenting conditions; then physical action to begin activities related to those conditions; and finally, mental action to exert control over the situation, combined with physical action intended to achieve goals. Orlando (1972) stated that nursing actions are precipitated by the nurse's reactions. In the reaction sequence, the nurse perceives the patient's behavior through any of the senses. Perception leads to thought that automatically produces a feeling. According to Orlando (1972), this process occurs simultaneously, but she cautioned it is not helpful to the patient until the nurse explores the validity of the reaction with the patient. After the nurse's reaction is validated or corrected with the patient, the nursing process continues with the nursing action.

Orlando (1972) identified two ways the nurse can act: automatically or deliberatively. Automatic actions are those carried out without exploration of the patient's need or consideration of the effect on the patient. They are described as nondeliberate actions that occur for reasons other than the meaning of the patient's behavior or immediate need for help. Orlando (1972) defined deliberative nursing actions as those designed to identify and meet the patient's

immediate need for help and, therefore, to fulfill the professional nursing function. Deliberative actions require validation of perceptions with the patient before it can be determined what nursing action will meet the patient's needs.

Impact

The impact of nursing actions is the focus of the evaluation phase of the nursing process. Following the nurse's actions, King's theory (1981) requires an evaluation that looks at the outcome both for goal attainment and for the effectiveness of nursing care. Evaluation is also inherent in Orlando's (1961) theory since the criteria for deliberative action includes determining its effectiveness once it is completed. Orlando (1961) emphasized that the nurse must ascertain how the patient is affected by what is said and done and whether the patient has been helped.

In Watson's (1989) model of human care, the goal of nursing extends beyond simple evaluation to helping patients find meaning in their experiences and in their existence, and to facilitate the patient's attainment of self-knowledge, control, and inner harmony. The patient has opinions and meanings attached to the health-illness experience and concerns about the meaning of life tend to be most urgent when the person's existence is threatened (Watson, 1985). Watson (1985) asserted that people generally benefit by determining the meaning of their experience and having that meaning

incorporated into the professional's response to the situation. Thus, the impact component of intervention must include the effect of nursing actions, the appropriateness of those actions for the desired goal, and the meaning of the outcomes and experience to the patient.

It is important to explore what measures NDErs perceive as helpful in dealing with the event, from the initial moments of "return", through time as the NDE is assimilated. The nature of any interventions employed must be evaluated for NDErs perceptions of the actual effects of the actions. Individual differences may occur as to positive or negative interventions and there may be cues to observe in determining the best interventions for each particular patient. The overall impact of the NDE to the patient may also reveal information pertinent to clinical practice.

Statement of Purpose

This study explored NDE patients' interactions with health care workers and significant others concerning the NDE, the perceptions and communication in the disclosure of an NDE, the interventions encountered in response to the patient's NDE, the effects of nursing actions and the overall impact of the NDE. The first overall research question that guided the investigation was:

What are the characteristics of the interactions that NDE patients have with health care professionals and significant others concerning the NDE?

Specifically, this research sought to answer the following questions:

a. When do NDErs first discuss the event?

b. With whom do NDErs choose to discuss the NDE?

c. How do NDErs choose a person to talk with about their NDE?

d. What specific behaviors, actions, or cues do NDErs interpret as positive promoters for disclosure and discussion of their NDE?

e. What specific behaviors, actions, or cues do NDErs interpret as negative or inhibiting to disclosure and discussion of their NDE?

f. How do NDErs perceive that health care workers react or respond to initial disclosure of the NDE?

g. How do NDErs perceive that significant others react or respond to initial disclosure of the NDE?

h. How do the perceived responses affect the NDEr?

The second overall research question was:

What nursing interventions for NDEs are recognized by patients and what effects do NDErs perceive from each?

a. What interventions did the NDErs perceive relating to the NDE?

b. What interventions were positive and in what ways did they help the patient?

c. What interventions were negative and how did they affect the patient?

d. What other interventions do NDErs recommend would be helpful?

The final research question that guided this study was: What is the overall impact of the NDE as perceived by the experient?

Summary

Patients who have been revived when clinically near death, often report having a unique subjective experience that involves memory of a time they were unconscious and a glimpse into "another realm" of existence. NDEs have characteristic traits which seem unbelievable and may elicit a wide range of responses from both experients and listeners. Surveys of health care workers show controversy concerning the belief in NDEs and insufficient knowledge of the NDEs or appropriate interventions. Their limited awareness of the phenomena is likely to decrease effective interaction with experients. This study explored NDE patients' interactions with others concerning the perceptions and communication in the disclosure of an NDE, the interventions encountered in response to the patient's NDE, the effects of nursing actions and the overall impact of the NDE.

CHAPTER TWO

REVIEW OF LITERATURE

The purpose of this chapter is to present a summary of the common characteristics of NDEs (near-death experiences) and a brief historical review of the knowledge and research of NDEs. A selected review of literature is also discussed, based on the two main concepts of the framework, interaction and intervention, and the subcomponents of each concept.

Characteristics of NDEs

It has become difficult to define death, based on clinical criteria, as the line between life and death blurs and lingering deaths amid high technology increase. It is clearly established in scientific and medical literature that there is no one point of total organism death, but rather a gradual dying process (Morse, 1990; Oakes, 1981). Dying may be viewed as a process that begins with cessation of respiration an/or circulation and ultimately ends in the irreversible cessation of all spontaneous vital functions (Lee, 1978). Near-death events occur during a stage in the dying process from which the patient may still return to life. Not all persons experience an NDE in near-death situations, but those who do consistently report many of the same common features. While NDEs are intensely personal and specific details are unique to the individual with many variations of the various elements, the NDEs do have general

characteristics that are universally noted (Moody, 1988, Ring, 1984, Sabom, 1982; Stevenson & Greyson, 1979). However, not all persons who have an NDE experience all of the traits. NDEs may consist of any combination of one or more of the common elements (Moody, 1988, Morse, 1990, Ring, 1980, Sabom, 1982).

The core elements of the NDE include: separation of mind from body; a sense of being dead; a sense of overwhelming peace; entrance into darkness or a tunnel; an encounter with other beings; an encounter with a Supreme Being of Light; a life review; a sense of all-knowing; entrance into a beautiful place; and return to the body. Some of these elements, such as entering a beautiful place and seeing cities of gold, are reported less frequently. The longer the length of clinical death, measured in earthly time, the more elements the NDEr is likely to encounter. Negative NDEs, although rarely reported, do occur and will also be discussed briefly in this section.

Separation of Mind From Body

The most common characteristic is the separation of the mind or consciousness from the physical body (Corcoran, 1988; Greyson & Stevenson, 1980). Patients frequently report the sensation of floating upward and the ability to observe and hear all that is happening. They see their body below, but often feel detached from it. They feel they have some body

form and all of their senses are heightened or hyperalert (Moody, 1975; Greyson, 1983). If their physical body was deformed in some way, it is restored in their new form. Experients may also discover that they can travel wherever they wish, almost instantaneously by thinking where they want to go. They may go through walls or travel large distances. They may observe other patients in other rooms or concerned family members and friends waiting elsewhere in the hospital or even in their homes. Experients often relate that they wanted to communicate with their family or the health care professionals but were unable to talk to or touch them. This time can be confusing or puzzling to experients as they try to understand what is happening (Moody, 1975).

Sense of Being Dead

Part of the NDErs' confusion results because NDErs feel alive and well, but observe others attempting to help their physical bodies. During resuscitation attempts they may hear comments about "losing him" or "he's gone/dead". The inability to communicate with others combined with the comments they may hear, lead NDErs to realize they must be dead. This may bring deep feelings of sadness or loss for the family that is left behind and the grief they will feel. Upon revival, patients often refer to "returning from the dead" (Greyson & Stevenson, 1980; Sabom, 1982).

Sense of Overwhelming Peace and Love and Painlessness

When the mind separates from the body, the person becomes aware of a peaceful feeling and cessation of any pain felt by the physical body. Experients may watch procedures performed on their body, such as defibrillation, but feel none of the sensations. Patients often describe feelings of overwhelming peace and calm, serenity, tranquility, and total love. Most NDErs state there are no words that adequately describe the wondrous feelings they experience (Moody, 1975, Serdahely et al., 1988; Ring, 1980).

Entrance into Darkness or a Tunnel

Some people report entering a dark or gray void in which they may either feel infinite space around them, or they may sense, but not see, some boundary that forms an enclosure. More commonly, experients recount entering a dark tunnel and being propelled a great distance at high speeds (Greyson & Stevenson, 1980). A loud noise, such as a buzzing, humming, ringing, or whoosh frequently is heard during this time (Papowitz, 1986). There is nearly always a radiant light at the end of the tunnel, which experients find they are anxious to reach. In a few NDEs reported by children, instead of the tunnel, they found themselves climbing a dark staircase toward the bright light (Morse et al., 1986).

Encounter with Other Beings

At some point in the NDE experients may meet other beings (Greyson & Stevenson, 1980; Moody, 1975; Sabom, 1982). The beings of light may appear to be all in white and the experient senses that they are a guide or angel. Communication with the beings is telepathic (Oakes, 1981; Ring, 1980). Children often relate that an angel will introduce themselves by a first name and assure the child they are there to help them (Morse, 1990). The beings are usually encountered either in the tunnel or after entering the light at the end of the tunnel. Many people recognize the beings as deceased relatives or friends; in some cases they are even deceased relatives whom the person has never met in life (Moody, 1988, Morse, 1990; Stevenson & Greyson, 1979). Almost always, individuals comment that they felt immense love and comfort from these beings. Children have also reported being met by deceased pets (Serdahely, 1990).

Encounter with a Supreme Being of Light or Deity

Experients may also meet a Supreme Being of Light whom they identify as a deity or a superior being (Moody, 1988). Depending on their religious background they may describe the Being as God, Jesus, Buddha, or Allah. Regardless of religion, the individual identifies the Being as very holy, total love, or simply as a Supreme Being. The Being is described as a living light, far more brilliant than our sun,

yet it is possible to see without hurting the eyes (Oakes, 1981). Furthermore, the Being radiates such total love, understanding, and acceptance that the experient wants to be with it forever (Moody, 1988, Sabom, 1982).

Life Review

When the life review occurs, it is not according to time as we know it. The person's whole life may be viewed all at once--a full-color, three-dimensional, panoramic review of every thing the person has done in life (Moody, 1988). Along with seeing every action in life, the experient may perceive immediately the effects of every one of those actions on the people involved. A few people report seeing a flash forward glimpse into their future. The Being of Light may be with the person through the review helping to put the events in perspective. Most people assert that they feel no judgment from the Being. However, individual experients are so deeply affected by what they liked or disliked about their actions in life that they come to their own personal judgments about themselves (Ring, 1980, 1984; Sabom, 1982). There is a strong sense that loving and caring about others is the most important thing in life. Reports of a life review occur more often in adults and are rare in children's accounts of NDEs (Morse, 1990).

Sense of All-knowing

In describing the sense of all-knowing, most people ultimately relate that it is indescribable in the language and concepts we have for expression. In this vision of knowledge, people may get a brief glimpse of a separate realm of existence in which all knowledge--past, future, and present--seems to coexist (Moody, 1977). Any questions the experients express are answered instantly, though they are not always allowed to remember the answers when they return to life (Ring, 1984). Some people relate "libraries" that when viewed give the person total understanding of a field of knowledge such as engineering or chemistry. It may also be described as a flash of universal insight or enlightenment during which the NDEr has complete knowledge (Moody, 1977).

A View of or Entrance into a Beautiful Place

Most NDErs qualify their descriptions of this experience indicating that it is a place of indescribable beauty, splendor, and peace, beyond comprehension of anything known in life (Moody, 1975; Ring, 1980; Sabom, 1982). Beautiful mountains, green meadows, gardens filled with flowers, vivid new colors unlike any seen on earth, beautiful music, and singing are only a few of the surroundings that may be described. The place is filled with the bright light and feelings of love, peace, and contentment. All sense of time is lost throughout the NDE (Freeman, 1985). In some cases,

there is a distant view of cities of light or gold (Moody, 1977). Frequently, experients sense a barrier or boundary and know instinctively that crossing it would mean they could never return (Corcoran, 1988).

Return to Body

During the NDE, experients may be given a choice to stay or return to life. In many cases they are told they must return; others find themselves returning after thinking about a loved one left behind (Matson, 1975; Morse, 1990; Sabom, 1982). However, many experients also relate that despite wanting to stay forever, they are suddenly returned to life (Moody, 1988; Ring, 1984). The return to the body is usually instantaneous and painless.

Negative Near-death Experiences

Not all NDEs are pleasant, although accounts of negative experiences are very rare (Moody, 1988; Sabom, 1982). When they do occur, they are often quite frightening and the survivor may show great trepidation (Judson & Wiltshaw, 1983; Oakes, 1981; Rawlings, 1978). Some of the traits reported are: feeling terror-stricken, helpless, and out of control; being trapped or immobilized in a total black void; having excruciating and intolerable pain; and meeting an apparition of a shrouded faceless figure beckoning with a cold, gray, icicled hand (Atwater, 1988; Corcoran, 1988; Judson & Wiltshaw, 1983; Lee, 1978; Oakes, 1981). Other respondents

report glimpses of hell: a lake of fire; bizarre creatures that attempt to devour the person; a scene with innumerable souls moaning, groaning, and viciously slashing out; and figures of a devil (Atwater, 1988; Oakes, 1981; Rawlings, 1978). Rawlings (1978), a cardiologist, reports that some patients relate hellish accounts either during resuscitation or immediately afterward, but later have no memory of the event. For others, it is an experience that requires long-term support and follow-up counseling (Atwater, 1988; Lee, 1978; Oakes, 1981).

Historical Review

Accounts of NDE phenomena and belief in an afterlife date back to very early time. Even the Neanderthal and the Cromagnon man of 75,000 to 25,000 years ago believed that the dead live on in some spirit form (Freeman, 1985). NDEs were not considered paranormal or supernatural in ancient times and were even expected (Moody, 1990; Rawlings, 1978).

Plato, the Greek philosopher who lived from 428 to 348 B.C. devoted much of his writing to the fate of the soul after physical death (Moody, 1975). Moody (1975) cites the account of Er, a Greek soldier in Plato's The Republic, which bears striking similarities to the recognized features of NDEs. In this myth, Er is killed in battle and his body placed with other dead soldiers on a funeral pyre to be burned. Er later revives and recounts that his soul went out of his body, he

joined a group of other spirits, and they went to a passageway leading from earth into the realms of the afterlife. After seeing many sights, he was told he must return to the physical world to inform others about the realm beyond, and Er awoke on the funeral pyre. Plato warned in his writings that trying to explain the afterlife while the soul was imprisoned in a physical body was very difficult, because of the limitations in what can be experienced and learned by the physical senses, and because human language is inadequate to directly express the ultimate realities (Moody, 1977; Rawlings, 1978).

The Tibetan Book of the Dead is also cited for its detailed account of death and life beyond and is remarkably similar to twentieth-century accounts (Moody, 1977, Morse, 1990). According to Moody's (1977) research, this work was compiled from sages over many centuries in prehistoric Tibet, passed initially by word of mouth, and finally written down in about the eighth century A.D. It was read to people as they were dying and also as part of the funeral ceremony. Its purpose was to help the dying as they experienced "each new wondrous phenomenon" (Moody, 1977, p. 120). Secondly, the book was read to help those still living to think positive thoughts and to let go, allowing the dying one to enter into the afterdeath planes, released from all bodily concerns. In the Tibetan Book of the Dead, the mind or soul of the dying separates from their physical body but they may not realize

they are dead until they see, hear, and attempt unsuccessfully to communicate with relatives and friends mourning over the body. After the separation, they are in a body form called the "shining" body, which has keenly intensified senses and can travel instantaneously, through walls, rocks, or anything, simply by thinking or wishing where it wants to go (Moody, 1977, p. 121). Any limitations that had crippled the persons in physical life, such as blindness or deafness, are restored. They may encounter other beings of the same kind, as well as a form of reflection that presents their entire life for review. In the review, all of the person's earthly deeds are laid bare and misrepresentation is impossible. They also encounter a clear or pure light and have feelings of immense peace, love, and contentment. The dying are counselled to move toward the union of their soul with the "Great Body of Clear Light", the source of life and light, into the state of "Perfect Enlightment" (Morse, 1990, p. 82).

The Tibetan manual for dying parallels other ancient teachings. Ancient Egypt was one of the greatest civilizations in history, with knowledge and capabilities that modern science is still trying to explain. In Egyptian civilization, each new king was supposed to be a direct reincarnation of their god-king Osiris, and was required to go through a reenactment of Osiris's entombment as a prerequisite for becoming a king (Morse, 1990). During this

ritual, the person was sealed in an airtight container and nearly suffocated. After a specified amount of time, the casket was opened and the person was revived. This people's understanding of the death process is recorded in The Egyptian Book of the Dead, which gives a detailed description of an NDE. It describes a judgment scene, other beings and voices, a boat trip through a dark tunnel, and ends with union with a bright light (Morse, 1990). Morse (1990) relates that the NDEs gave the kings a sense of all-knowing, and, as with modern accounts, transformed them into people with a reverence for the love of others and a caring and interest in the universe and the world around them. It is interesting to note that during the reign of the kings who had induced NDEs, the Egyptians garnered vast knowledge about the world and enjoyed unusual peace and prosperity for two thousand years (Morse, 1990).

Like the Tibetans and Egyptians, the Aztecs had a book that served to enlighten their people about the world beyond. The Aztec Song of the Dead is a poetic version of a near-death experience that, according to Morse (1990), scores at the top of the Near-Death Experience Validity Scale developed by Ring (1980).

Recordings of NDEs are not unique to the ancient and eastern cultures. The Christian Bible refers to life after death, with accounts that have features suggesting possible

pre-death and near-death experiences (Matson, 1975; Moody, 1975; Morse, 1990; Walker & Serdahely, 1990). One example is in Acts 7:54-58 of the Bible. Before being stoned to death, the apostle Stephen had a vision, in which the heavens opened and he saw the glory of God and the Son of man standing at the right hand of God (Moody, 1977). Numerous accounts of NDEs which are similar to contemporary accounts are found throughout time, as early as 731 A.D., and in various cultures including, Celtic, Irish, Swedish, Swiss, English, German, Mexican, New Zealander, and American (Freeman, 1985; Matson, 1975; Moody, 1975; Stevenson & Greyson, 1979). Stories of NDEs are readily found in the literature in the 1800's and in every decade of the 1900's (Freeman, 1985; Matson, 1975; Walker & Serdahely, 1990). Despite the long-standing history of NDEs, and their consistent occurrence through the ages, research and application of NDEs is relatively new to modern science and medicine.

According to Morse (1990), the scientific revolution created a schism between science and the church. Where religion was once incorporated into healing practices, it was omitted as physicians were forced to choose between theology and science. As medical knowledge advanced, saving lives at all costs through aggressive medical intervention became the focus. Death became unnatural, a failure of modern medicine. The loss of religious involvement in the healing and dying

process changed societal attitudes about death, creating a phobia of death. The medical establishment viewed NDEs as abnormal. The shunning of natural death and NDEs by the scientific fields, caused both to be regarded as freakish or supernatural and resulted in the suppression of open discussion and recounting of the phenomena. The existence of NDEs however, has endured. It is such a profound event, experienced by growing numbers of people, that it can no longer be ignored by health care professionals.

More than 20 years ago, a resurgence of interest by members of the various scientific fields began. In the early 1960's Osis and Haraldson, two parapsychologists, solicited reports from more than 5,000 physicians, nurses, and patients of over 35,000 accounts of deathbed visions and NDE observations (Oakes, 1981). This survey was conducted in the eastern United States, followed by a comparison study in 1972 of similar numbers of patients, physicians, and nurses in Northern India. The results of the second study showed no notable differences between the reports of NDEs made by Indians and those made by U.S. respondents (Oakes, 1981; Walker & Serdahely, 1990).

In 1975 Moody, a psychiatrist, popularized the phenomenon when he published a book that described interviews with more than 150 NDErs and identified several common characteristics related by a diverse group of individuals. Moody (1975) then

challenged the scientific community to further study this phenomenon. The publication of Moody's (1975, 1977) research, reported as anecdotal findings, elicited more open and public discussion of NDEs. Since then, there have been a number of scientific investigations with published reports in medical and nursing journals (Corcoran, 1988; Greyson, 1983; Morse et al., 1986; Ring, 1980, 1984; Sabom, 1982). Additionally, large circulation magazines began disseminating descriptions of NDEs; thus most of the Western world has been exposed in some degree to NDEs (Oakes, 1981).

The first scientific study of NDEs was a comprehensive investigation by Ring (1980), a psychologist, which elicited both quantitative and qualitative data. He interviewed 102 people who had come close to death or been resuscitated from clinical death and found that 49 (48%) described an NDE that fit the core concept outlined by Moody (1975, 1977). Another impressive study by Sabom (1982), a cardiologist, produced results that were similar to Ring's (1980) and upheld Moody's (1975, 1977) findings. Of the 116 near-death survivors (mostly from cardiac arrests) interviewed in Sabom's (1982) study, 49 had experienced the general features of an NDE. In both studies, it was determined that a person's age, sex, race, area of residence, education, occupation, religious background (or lack of), and frequency of church attendance did not affect whether or not the person had an NDE (Ring,

1980; Sabom, 1982). This supports the findings in studies by Osis and Haraldson (Freeman, 1985).

While the previous studies involved adult respondents. Morse (1990), a pediatrician, studied the occurrence of NDEs in children. He was drawn into the research after the miraculous recovery of a young near-drowning victim who later surprised him with an accurate account of her resuscitation and the story of her journey to heaven. In his research study, he interviewed all subjects using standardized questions. The medical records of all patients were closely examined to document all treatments, laboratory studies, and events. The control group consisted of 121 children who were critically ill but not near death. These children, ages 3 to 16, were in the intensive care unit, "on artificial lung machines" and treated with tranquilizers and narcotics (Morse, 1990, p. 19). None of the 121 children in this group had anything resembling an NDE, and 118 had no memory of their hospital stay. Morse (1990) also interviewed 37 other children outside the control group who had been treated with mind altering medications: anesthetic agents; narcotics; Valium; Thorazine; Haldol; Dilantin; antidepressants; mood elevators; and pain-killers. Again he found that none of them had anything resembling an NDE.

Morse's (1990) study group consisted of twelve children who survived near-fatal incidents such as cardiac arrests,

near-drownings, automobile accidents, or diseases such as severe kidney problems and asthma. Eight of the survivors, nearly 70%, had experienced features of NDEs. Many recounted accurate details of the medical interventions administered while they were unconscious. The stories of the children's experiences of leaving their bodies and traveling to "another realm" parallel accounts of adult NDEs.

Skeptics have attempted to explain NDEs as a physiological, neurological, or psychological state. Theories include: oxygen deprivation of the brain; hypercarbia; pharmacological-induced effects; optical abnormalities; massive endorphin release; autoscopic hallucinations; and seizure disorder (Corcoran, 1988; Moody, 1988; Ring, 1980). Some of the psychological theories are: schizophrenia-related psychosis (which includes hallucinations and delusions); wish-fulfilling dreams; depersonalization; denial; and memory leftover from the birth experience (Freeman, 1985; Greyson, 1983; Moody, 1975, 1988). These theories not only prove inadequate in that they are not supported by any of the research to date, but they also fail to account for some of the vivid characteristics of NDEs and their universal occurrence (Corcoran, 1988; Freeman, 1985; Moody, 1988; Morse, 1990; Ring, 1980; Sabom, 1982).

Interaction

This section addresses the literature related to the concept of interaction and its subcomponents, perception and communication. The occurrence and characteristics of NDEs has been the primary focus of research, with interactions related to the disclosure of the NDE reported as incidental information. Health care workers' knowledge and attitudes concerning NDE's has been studied, but not the effects of these factors on interactions with NDE experients (Hayes & Waters, 1989; Oakes, 1981; Orne, 1986; Walker, 1989). There is a wide variation in the time between the NDE and when patients first talk about their experience. Some patients attempt to express their feelings and experiences immediately, while others have been found to keep it a secret for up to 20 years (Walker, 1989). These findings came in anecdotal accounts from Moody (1975; 1988) or were related as incidental findings in Ring's (1980) and Sabom's (1982) studies. No studies were found that examined the disparity or factors specifically affecting disclosure of the NDE.

Ring (1980) and Morse (1990) both express the opinion that professionals who are ignorant of the NDE phenomenon may inadvertently be obstacles to patient's attempts to discuss, understand, and assimilate the experience. Not all health care workers are cognizant of what patients experience. Sabom (1982) distributed questionnaires to paramedical personnel,

physicians, and nurses who had worked closely with a hospital population in which 43% of near-death survivors had been found to recall NDEs when interviewed. Of the 95 health care workers who responded, only 10 were aware that an NDE had occurred to one of their own patients. This indicates less than optimum communication with patients and a potential for improvement in health professionals' interactions with NDE experients.

The patient's perspective seems to influence their interactions with others. According to Corcoran (1988), patients are extremely vulnerable following an NDE and may already feel rejected at being returned to life. Oakes (1981) concluded "a consensus of statements by NDE survivors taken from similarly designed studies showed that patients assumed disbelief from any listener..." (p. 73). Although no data was presented on the incidence of his observation, Sabom (1982) noted that patients were sometimes reluctant to share or initiate discussion about their NDEs. Oakes interviewed 21 post-resuscitation patients and indicated that "most of the patients" didn't seek the opportunity to tell about their NDEs for fear of being considered crazy (Lee, 1978, p. 55).

Data describing with whom patients confide about NDEs is lacking. Lee (1978), a registered nurse who personally experienced an NDE, wrote that patients frequently won't mention their subjective experiences of death or of a world

beyond to doctors, but will talk about it to a nurse. He also cited Martinson, a director of research at the University of Minnesota School of Nursing, who stated that "it's usually the nurse to whom the patient will open up and it's up to nurses to understand what's happening" (Lee, 1978, p. 64). However, no research data were presented for these conclusions. Oakes (1981) reported that "the NDE survivor usually selects one trusted nurse, less frequently another caregiver, and almost never calls for a member of the clergy to share the intimate details of near death phenomena" (p. 72). Presumably this information is drawn from her interviews with 21 post-resuscitation patients, although publication of the details of her study was not found.

Perception

Subcomponents of interaction include perception and communication. Documentation of patient's perceptions is inadequate and mostly through anecdotal reports. Sabom (1982) suggested that most NDErs will talk if they perceive someone is willing to listen attentively to what is said. Following her interviews of 21 patients, Oakes indicated experients readily opened up to discussion once they were assured the interview would be taken seriously and they felt comfortable with their surroundings (Lee, 1978). She concluded that "the reluctance of patients to initiate discussions about near-death phenomena has been proportionate to the perceived

reception to this untested information" (Oakes, 1981, p. 72). Publication of the specific raw data from which this was drawn was not found.

Perceptions were a primary concern for Serdahely et al. (1988), who anecdotally reported three examples of patient experiences. In relation to health care workers, one patient felt the physician became defensive and dismissed her NDE as imaginary. She perceived nurses as being more sensitive to her paranormal experience than doctors. This patient thought the doctor was stupid to say she was close to death and was angered that he told her husband she might die. She was also angry that the Emergency Room staff talked about her as if she couldn't hear them during her NDE. A second patient reported she was confronted by a nurse after regaining consciousness because the nurse did not believe she was really sick. This patient specifically stated that she did not confide in any of the nurses or doctors because of their brusque treatment of her. The third patient, while in the out-of-body state, heard his doctor remark that nothing was seriously wrong with him and he was not anywhere near death. This patient did not express his NDE to any of the health care members. Clearly, perceptions were formed by these three patients based on the treatment they received and attitudes displayed by health care workers which the patients saw and heard while in the out-of-body state.

Two of the patients interviewed by Gerdahely et al. (1988) also described attempts to talk with family members. One patient told his father who shrugged it off saying that it was a dream or hallucination. Consequently the patient decided to keep the NDE to himself, feeling no one would believe or conceive of such an experience. The second patient tried to discuss her NDE with her sister to whom she was very close. However, the sister told her not to talk about it or people would think she was crazy. Reports of similar responses by health care workers and family members are noted in Moody's (1975) anecdotal accounts and in Ring's (1980) and Sabom's (1982) studies.

A few studies have explored the perceptions of health care workers that affect their interactions with NDErs. In a survey of 30 critical care nurses, polled for their reaction to ten anecdotal cases of NDEs, Oakes (1981) found responses included disbelief and skepticism with comments such as "weird", "a scam", "religious nuts", and "psychiatric blowouts" (p. 73). She also reported that "some" nurses were interested but did not want to be identified for fear their colleagues would brand them as inappropriate and unreliable nurses (Oakes, 1981, p. 73). In a follow-up study conducted three years after the initial study, Oakes (1981) informally surveyed a small group of critical care nurses using the same study design. She concluded that their responses were more

open and responsive toward the phenomena. She also noted that the critical care nurse group surveyed in the second study perceived themselves "best able to listen, able to respond with more objectivity than any other care givers and able to provide more consistent support in dealing with issues of NDE reporting and collegial interactions but with less finesse when the patient showed signs of fear, sluggishness..., or preoccupation..." (Oakes, 1981, p. 74). In the study by Hayes and Waters (1989) which compared health care workers subjective rating of their knowledge of NDEs with objective tests on the topic, the researchers concluded that "the perceived knowledge of nurses, clergy, and physicians about the NDE was not validated by the actual knowledge scores" (p. 452).

Communication

Information about disclosure of NDEs was sometimes relayed incidentally, though no studies were found that directly studied this component. Because many survivors who had out-of-body experiences described in great detail all that was said and done, giving near-verbatim accounts of conversations that occurred while in that state, Lee (1978) advised that all conversation should be calm and professional. He noted that a tone of panic could register with such patients as surely as words of panic. During resuscitation periods, health care professionals should be aware that the

unconscious patient may still hear and accordingly, curtail careless language and conversation and treat the patients with respect (Dougherty, 1990). Statements made at this time can impact on the patient's willingness to disclose.

Disclosure may be difficult for both the NDEr and the listener. Oakes (1981) stated that the teller and the hearer may be sending and receiving on two completely different wavelengths. She indicated that the listener can begin to appreciate the patient's viewpoint only by listening honestly and dispassionately. Drawing pictures was one method that helped initiate discussion and clarify concepts of the NDE; it was especially useful with children (Morse, 1990; Strom-Paikin, 1986). Often, NDErs wanted assurances of confidentiality. Some of the physical and nonverbal cues patients specifically requested to indicate this were closed doors, quiet voices, and no disclosure of information via notes or tapes (Oakes, 1981).

One of the NDErs interviewed by Serdahely et al. (1988) addressed the nonverbal messages she perceived while relating her NDE to fellow classmembers. She had second thoughts about disclosing her experience because she perceived the class looked bored and disbelieving, and she interpreted their facial expressions to mean "she's off base" (Serdahely et al., 1988, p. 240). She indicated it would have been helpful to her for someone to convey a message that her experience was

not strange, weird, or dumb. Lee (1978) advised that nurses should communicate to patients that their NDEs do not indicate a mental disorder.

Intervention

Literature related to the concept of intervention will be reviewed along with its subcomponents, action and impact. The clinical application of NDE's is not well established and there is little research reported that analyzes the effects of interventions (Hayes & Waters, 1989; Serdahely et al., 1988). Oakes (1981) asserted that health care professionals cannot ignore NDEs and must develop ways to reach across this dimension of human experience while caring for NDE experients. Based on his own NDE, a review of research reports, and interviews with both NDErs and experts who deal with CPR experiences, Lee (1978) concluded special nursing support is necessary to help patients "survive their survival" (p. 59). He insisted that any realistic care plan must take into account the various types of experiences and the various kinds of responses of revived patients. Patients who have had negative NDEs usually have different needs from those who have had pleasant experiences (Lee, 1978; Oakes, 1981; Rawlings, 1975). An important goal identified by the International Association for Near-Death Studies, Inc. (IANDS) is to promote research and educate professionals about how to help NDErs

integrate the experience into their lives (Strom-Paikin, 1986).

Several nurses have published guidelines for dealing with NDE patients (Corcoran, 1988; Dougherty, 1990; Lee, 1978; Oakes, 1981; Papowitz, 1986; Serdahely et al.; Strom-Paikin, 1986; Trevelyan, 1989; Walker, 1989). In a survey of nurses who reviewed anecdotal cases of NDEs, Oakes (1981) found that only 6 of the 30 nurses considered the NDE survivors' experiences to have an influence on all succeeding plans and care. She noted however, that while some nurses acknowledged that the NDE was important, they were at a loss as to how it should be incorporated into nursing care.

Later, Orne (1986) surveyed 912 nurses and found that while 70% said they were familiar with NDEs, 849 respondents or 93% said a patient's report of an NDE would have little or no influence on their nursing care. Orne suggested there were three possible interpretations for this finding. She felt it could mean that nurses would fail to include a very significant patient experience in their care plan; or that nurses would not alter their care because they were unsure what to do; or that they would not think negatively about the patient. Almost all of the nurses expressed the desire to learn more about NDEs and ways to deliver more effective nursing care for such patients.

In the most recent study, Hayes and Waters (1989) surveyed 578 registered nurses, physicians, and clergy. Overall, 70% indicated familiarity with NDEs. They were divided into two subgroups based on whether or not they were familiar with the phenomenon. Eighty percent of the subjects felt the NDE should be incorporated into the provider's professional interactions with the patient. Depending on the subgroup however, 25% to 40% of the providers were unable to identify any interventions. The mean number of interventions given by individual respondents was only one. There was a significant positive correlation between the scores on the test of actual knowledge and the number of interventions identified. These studies indicate a need for more nursing research related to interventions.

Action

Actions, which are deliberate measures designed to meet the patients needs, are preceded by reactions. Hayes and Waters (1989) found that 29% of the health care providers surveyed indicated that their first reaction to an account of NDEs was one of disbelief. Reactions from providers, family, and friends related by patients include disbelief, attempts to suppress discussion, alternate explanations, and perceptions that the patient is mentally disturbed to some degree (Moody, 1975; Ring, 1980; Sabom, 1982; Serdahely et al., 1988). Personal introspection, professional education,

and patient care conferences are recommended so that providers can share ideas and feelings and work through their own reactions to NDEs in order to better incorporate the experience into the patients care plan (Hayes & Waters, 1989; Lee, 1978).

Research related to specific interventions is lacking. One study of 20 survivors of cardiac arrest, found that patients desired more discussion with the medical staff concerning their experiences, their fears, and information about what to expect and how to deal with it (Dobson, Tattersfield, Adler, & McNicol, 1971). While some of these patients may have experienced an NDE, this was not a variable that was specifically addressed. The recommended actions may be transferrable to the care of NDE patients. In the anecdotal accounts of the patients interviewed by Serdahely et al. (1988), other interventions were revealed. Patients recommended warmth, enthusiasm, willingness to listen, and reassurance about the widespread nature and antiquity of NDEs. These findings are consistent with advice expressed by other NDErs (Moody, 1975, 1988; Ring, 1980; Sabom, 1982). NDErs also expressed a strong desire to be believed and stated that following any sign of disbelief, they quickly aborted attempts to share their experiences and feelings. In Oakes' (1981) research, she wrote that patients informally stated to her that they preferred tc have a health care provider present

when they told family members about the NDE. This support was viewed to lend credence to the experience. From his personal experience following an NDE, Lee (1978) recommended: assurance during resuscitation, even if the patient is unconscious; providing privacy to survivors; support if the NDE patient is later in the proximity of other patients in cardiac arrest; preparation of the family; open-ended questions to elicit information; and help in reconstructing events that confuse and worry the patient.

Impact

There is a paucity of published research that specifically examined the effectiveness or impact of interventions related to NDEs. Some effects are reported incidentally. Orne (1986) cited the need for research to determine what strategies for care of NDErs are most needed, and whether coping is influenced by what is or is not said or done by nurses.

Several researchers have commented that patients expressed gratitude and great relief when they were allowed to openly discuss their NDE, when they were reassured of their sanity, and when informed that many others also had similar experiences (Corcoran, 1988; Moody, 1975; Oakes, 1981; Ring, 1984; Sabom, 1982; Walker, 1989). Dobson et al. (1971) noted that providing information and allowing discussion with medical staff allayed anxiety of the patients and family

members. Among terminally ill children, Morse (1990) found that open and honest discussion of the patients' NDE transformed the dying process and deathbed scene from a "grueling nightmare to one cf love and joy" (p. 66).

The denial to share and validate their feelings resulted in post-NDE depression for some experients (Ring, 1984). Papowitz (1986), a clinical specialist in psychiatric nursing, stated that many patients she counsels have long-term unresolved concerns about NDEs, especially if they had been encouraged to forget, or suppress the memory.

The short-term and long-term impact of the experience on the patient should also be assessed (Lee, 1978). General effects of the overall experience have been addressed in several comprehensive investigations. Dougherty's (1990) belief that the NDE is a positive event that initiates a growth-process for the NDEr is supported by research findings (Noyes, 1980; Ring, 1984; Sabom, 1982; Sutherland, 1990). Even negative NDEs can cause experients to make positive changes in their lives and discover a deeper meaning in life (Corcoran, 1988; Rawlings, 1975). The overall impact the NDE for individuals include:

1. decreased fear of and new attitudes about death;
2. a sense of purpose or destiny in life;
3. a renewed will to live focusing on the present;

4. an increased value of love, compassion for others, and improving relationships;
5. a sense of the preciousness of life;
6. increased spirituality;
7. an intuitive acceptance of both life and death;
8. decreased materialism;
9. an appreciation of nature and greater regard for the universe;
10. a sustained sense of self;
11. a more passive attitude toward uncontrollable events; and
12. a belief in having received a special gift from God (Noyes, 1980; Ring, 1980; 1984; Sabom, 1982; Sutherland, 1990).

Some NDErs report increased psychic development which may be temporary or permanent (Ring, 1984). This may involve the ability to read minds, clairvoyant and telepathic experiences, precognitive flashes, deja vu experiences, seeing auras around people, and being much more intuitive and sensitive to others.

Difficulties in adjusting to "ordinary life", and frustration over the inability of others to understand or relate to the profound experience of an NDE are also quite prevalent (Walker, 1989). Ring (1984) noted a considerable

number of divorces following NDEs, although no formal research has addressed this.

Studies of attempted suicides indicate that if the patient experiences an NDE during the attempt, it has a profound positive effect (Greyson, 1981; Ring & Franklin, 1981; Sutherland, 1990). The incidence of NDEs in suicide survivors is similar to that in near-deaths from other causes. Seventeen of the 36 suicide survivors studied by Ring and Franklin (1981) had NDEs. For all of the NDE experients, suicide ceased to be an option. Greyson (1981) also found that the NDE promoted a strong anti-suicide orientation and emphasized the absence of subsequent mortality in those who attempted suicide and had an NDE, in contrast to the high subsequent mortality of those who did not encounter an NDE during their suicide attempt. The primary impact of the NDE, other than anti-suicide, was the same as seen in other populations. The NDErs felt a restored sense of purpose and value in life, an increased belief in existence after death, and a decreased fear of death.

Summary

The knowledge of NDEs and belief in an afterlife remains strikingly consistent throughout time and spans many diverse cultures, religions, and beliefs. The general features of NDEs described by people of ancient civilizations are amazingly similar to the characteristics found in NDE accounts

in more recent history as well as those described in scientific studies of NDEs. Common characteristics of NDEs include: a separation of mind from body; a sense of being dead; a sense of peace and love; entrance into darkness or a tunnel; an encounter with other beings; an encounter with a Supreme Being of Light; a life review; a sense of all-knowing; a view of or entrance into an indescribably beautiful place; and a return to the body. Negative NDEs have also been described, but these accounts are rare.

Some research into the NDE phenomenon began in the 1960's, but has met with much skepticism in the medical establishment and with attempts to explain away or dismiss NDEs. However, comprehensive scientific studies by investigators such as Ring (1980, 1984), Sabom (1982), and Morse (1990) have resulted in conclusive evidence that NDEs exist and have not been fully explained by any of the skeptics' alternate theories.

The clinical implications of NDEs need to be investigated further. Patients have indicated that they are reluctant to talk about their experiences because they perceived disbelief or were told it was psychological. Anecdotal accounts suggest patients need to talk about their experience and to feel it is accepted for the transcendental experience it was to them. When they are discouraged from talking about it or meet with skepticism, experients are less able to assimilate it into

their lives and may suffer post-NDE depression (Ring, 1984). Some experts suggest that patients often choose a trusted nurse to talk to first, but no research has been published to support this. Studies of health care professionals indicate that they lack knowledge and understanding of ways to help NDErs and to develop a care plan that incorporates the NDE to meet patient needs.

Several nurses have published guidelines for dealing with NDErs, however, there are no studies that explore the impact or effectiveness of those interventions. Anecdotal accounts suggest that patients are indeed affected by what health care professionals say and do concerning the NDE.

NDE experients assert that the NDE is a profound experience which they cannot ignore or forget. Studies indicate that NDEs, including negative NDEs, have consistently resulted in positive changes in patients' lives and attitudes toward how to live life. However, difficulty in adjusting to "ordinary life" and integrating the NDE is also reported. It is necessary to assess the short-term and long-term impact of the experience on each patient individually.

CHAPTER 3

METHODOLOGY

This chapter presents the research design, sample, setting, protection of human subjects, development of the instrument, data collection, assumptions and limitations of the study, and methods of analysis.

Research Design

A descriptive/exploratory research design was used to study the near-death experience. According to Burns and Grove (1987) a descriptive design provides a means of describing what exits, discovering new meaning, and categorizing information. Exploratory research is conducted to gain new insights and increase knowledge of a phenomenon (Burns & Grove, 1987). The intent of this study was to identify the perceptions and means of communications between the NDEr and health care workers and significant others, as described by the patient. The design was selected to determine what actions patients encountered as a result of the interactions concerning their NDEs as well as the positive and negative impacts of each intervention. This study also explored the overall meaning of the NDE as perceived by the experient. The study was deemed cross-sectional, as subjects were interviewed at one point in time, but time since the NDE varied by subject.

Sample

Eight adult near-death experients were interviewed. The time post-NDE ranged from 3-22 years. Network sampling was used to identify a purposive sample who had actually experienced an NDE. The subjects were recruited through community contacts that included a university instructor and an NDE experient. Criteria for inclusion were: 1) adults who experienced an NDE during an illness, injury, accident or means other than self-induced through meditation; and 2) willingness to discuss the event and have the interview tape-recorded.

Setting

The study was conducted in subjects' homes or other mutually determined sites such as a private office. The environment for the interviews provided privacy, comfort, and freedom from distractions thus facilitating discussion, ensuring confidentiality, and allowing for tape-recording.

Protection of Human Subjects

Prior to data collection, the study was submitted to the University of Arizona's Human Subject's Review Committee. A copy of the Human Subjects Approval letter is included as Appendix A.

There were no anticipated risks for participants in this study. Confidentiality was assured to all subjects and a subject identification letter was used to provide anonymity.

A disclaimer was read to each participant prior to the start of the interview (Appendix B). Responding to the interview questions was considered as consent. Subjects were informed that study participation was voluntary and that they had the right to withdraw at any time without penalty.

Data Collection

Prospective participants were contacted by telephone to elicit interest in participating in this study. The purpose of the study, time necessary for participation, format for tape-recorded interviews, confidentiality, and voluntary nature of participation were explained. Subjects' concerns were addressed and the investigator established that the persons met the study criteria. Thirteen prospective participants were contacted. Three people did not meet the study criteria for a near-death experience. Two other individuals declined interviews stating that the experience was "too personal" and one person added that "you might think I was crazy". An appointment time and place was established with person's who agreed to participate. Interviews required from 1-3 hours, with most averaging two hours.

Prior to the interviews, the disclaimer (Appendix B) was read to the subjects. Questions on the Demographic Data Form (Appendix C) were asked verbally with the investigator noting the response on the form. The interview questions (Appendix D) were read to participants. Subjects' responses to all

interview questions were tape-recorded. In some situations it was necessary to reorder the questions to follow the normal flow of conversation if the participant brought up something that was relevant to a later question. Both the respondents and interviewer asked clarifying questions. In addition, the interviewer asked probing questions to explore issues raised by participants, though caution was used to avoid leading the subject.

Following the interview, participants were given the opportunity to ask questions and share concerns about the NDE phenomenon or about the study itself. All subjects continued with some discussion and questions about the NDE phenomenon after the interview was completed.

All of the interviews were transcribed and reviewed by the investigator to verify that the transcription was accurate. Code letters were used for all respondents and any identifying information was altered or deleted.

Interview Questions

Demographic data were collected including age, sex, racial-ethnic background, marital status, religious preference or affiliation, education, occupation, approximate date of the NDE, and knowledge of NDEs, using the Demographic Data Form (Appendix C). The data obtained were similar to that obtained by Moody (1988), Ring (1984), and Sabom (1982).

A 14-item Interview Guide (Appendix D) was developed to elicit answers to the research questions. Open-ended questions were used to avoid leading questions and to allow subjects to communicate the ideas and events they felt were most important.

Question 1 asked the subject to describe the circumstances under which the NDE occurred in order to elicit the medical status of the patient at the time of the NDE and the environment in which the NDE took place. This question also provided an opportunity to develop rapport with the respondent and promote transition into the more personal interview questions.

In the second question, subjects were asked for a detailed description of their NDEs. This question ascertained which NDE elements each subject experienced and confirmed that the event qualified as an NDE. It also helped to establish experients' thoughts and feelings as they "returned" from the NDE and began the process of assimilating the experience and subsequent interaction with others. Since patients in the out-of-body state may hear and observe things which later affect their perceptions and willingness to relate the event to family or health care workers, this question was intended to elicit such information.

Question 3 explored the first time subjects had ever told anyone about their NDEs. This question operationalized the

first research question concerning the characteristics of NDE patients' interactions with health care professionals and significant others. It identified when and with whom the NDE was first discussed, and NDErs' feelings or ability to talk about their new experience.

Question 4 sought information about NDErs' perceptions of listeners' responses. It was designed to elicit specific details regarding the perceived reactions and responses of others upon initial disclosure of the NDE. Question 4 was asked to explore the verbal or nonverbal cues which led to those perceptions. In most interviews it was necessary for the interviewer to ask probing questions such as "What made you think the listener thought/felt that?" to draw out more details from subjects concerning these perceptions.

Question 5 inquired what specific behaviors or cues led NDErs to select the first person to confide in about the NDE. These actions were considered positive promoters for disclosure and discussion of NDEs. Questions 6 asked if there were previous attempts to tell someone about the NDE. Question 12 sought a description of behaviors and cues that cause NDErs not to talk about their NDEs. Questions 6 and 12 elicited the specific factors or cues that inhibited disclosure of NDEs.

Question 7 asked who else was told about the NDE after the initial disclosure. This was to determine whether

patients needs were met by talking with only one chosen person or if they sought more support. Additionally, it was an indirect indicator of the effect of the first encounter on further disclosure of the NDE.

The study sought information about interactions with two groups of people in particular, health care professionals and significant others. Question 1 elicited information about one group; in order to explore NDErs interactions with both groups, question 8 inquired whether each subject had also told a member of the second group.

Subjects were asked in question 9 to describe what actions were helpful, and in question 10, what actions were not helpful. These questions operationalized the second research question regarding the interventions NDErs perceived relating to their NDEs. Both positive and negative interventions were explored as well as the reasons the actions had that particular effect for patients. Question 11 expanded on that concept by asking what NDErs would have liked to have been done for them and what actions they recommended for new NDErs. This also allowed subjects to emphasize what they thought was important and to suggest new ideas about ways to help NDE experients.

Question 13 asked subjects to describe what the experience had meant to them. This was designed to answer the third research question regarding the impact of NDEs as

perceived by experients. After informants had replied, probing questions regarding such things as attitude changes and spirituality, were asked to explore their answers.

Question 14 inquired if subjects wished to add anything further to the interview. This final question allowed participants to discuss anything they felt was important that had not been addressed by the earlier questions.

Assumptions of the Study

This study was based on the assumption that NDErs have some need to talk about the event and that discussion with health care professionals or significant others is beneficial to the patient. Another assumption was that subjects would be inclined to share their NDEs, which are often intensely personal, if the interaction was a positive one that conveyed openness and a readiness to listen.

It was assumed that participants would be willing to share all of their experiences and would not selectively withhold portions that they might consider negative or difficult to relate. Finally, it was assumed that participants would be able to accurately recall their interactions with others regarding the disclosure of their NDE and the activities or events that followed.

Limitations of the Study

No attempt was made to ascertain whether participants actually had an NDE, other than their self-report and the

presence of one or more of the known characteristics of an NDE in the experients' NDE account. Verification using medical records or other personnel who were present at the time the patients had their NDEs was not obtained.

Another limitation was that since this was a retrospective review, there was no verification of the actual interactions and interventions that occurred between the patients and other people. There was no comparison of the patients' perceptions with the perceptions of the same events as seen by other personnel who interacted with the NDEr.

Data Analysis

The overall research questions to be studied were:

1. What are the characteristics of the interactions that NDE patients have with health care professionals and significant others concerning the NDE?
2. What nursing interventions for NDEs are recognized by patients and what effects do NDErs perceive form each?
3. What is the impact of the NDE as perceived by the experient?

Demographic data were analyzed to describe the age, sex, racial-ethnic background, marital status, occupation, education, religious background/affiliation of the sample,

time since the NDE occurred in each case and prior knowledge of NDEs.

Qualitative data analysis was used to answer the research questions. Analysis of the verbal data collected in the interviews required content analysis, a transitional process that allowed verbal responses and descriptions to be coded and analyzed. It is a procedure that categorizes verbal data for the purposes of classification, summarization, and tabulation (Fox, 1976).

Content analysis at the manifest level, which was used in this study, involves analysis of what respondents say, strictly bound by the response, without paraphrasing or making assumptions (Fox, 1976). The analysis is a direct transcription of the response in terms of some code, and can be accomplished reliably and validly (Fox, 1976).

There are three basic elements to content analysis. The investigator must: 1) select the unit of analysis; 2) develop categories and subcategories to classify the data; and 3) develop coding criteria or rationale to guide the placement of responses (Fox, 1976).

Unit of Analysis

The unit of analysis in this study was actual respondent statements. These were words, phrases, sentences, or passages that conveyed an idea or proposition about something. Kerlinger (1973) indicated that the use of direct subject

statements, without inferences or implied meanings, results in interpretations that are realistic and close to the original content and that maintain reliability and validity. Each statement which represented a different meaning, thought, or idea was categorized separately.

Development of Categories

This study involved cross-site analysis, which multiplies the data set by the number of subjects in the study. In this term, site refers to one case or one individual respondent (Miles & Huberman, 1984). Cross-site (or multicase) analysis provides the potential for both greater explanatory power and greater generalizability than a single-case study (Miles & Huberman, 1984). To manage the large amount of raw data generated in a qualitative study, the data must be refined, summarized, and reduced through partitioning and clustering so that it becomes ordered and meaningful (Miles & Huberman, 1984). All relevant data must be included. The analyst then partitions or divides the data. Data having similar characteristics are clustered into categories, classes, or bins. Miles and Huberman (1984) define clustering as the process of using and/or forming categories, and the iterative sorting of things into those categories. Clustering typically relies on aggregation and comparison and is a tactic which can be applied at many levels in the analysis.

The categories may be predetermined, or may emerge from the data. Most categories require other categories to define them (Miles & Huberman, 1984). Field and Morse (1985) recommend that initial categories be as broad as possible without overlapping. As more information is analyzed, the major categories may be sorted into smaller categories. This enables the data to remain manageable and permits subcategories that pull a great deal of material together into meaningful and parsimonious units of analysis. The initial choices guide the analyst to a certain way of looking at and making sense of the data, however it may later require much summarizing and reworking to refine the clusters or categories so they are clear (Miles & Huberman, 1984).

This research study began with some predetermined categories and subcategories; other bins or subcategories emerged from the data. The study framework provided the basis for initial conceptual clustering using the two main concepts of interaction and intervention.

Interaction was composed of two broad categories, perceptions and communication. These major categories were defined by other subcategories. During data analysis, some of the predetermined subcategories changed from those originally identified. For example, as the data were sorted, three subcategories were identified under perceptions. The planned subcategories for communication were verbal and

nonverbal, but instead, data were sorted into a communication process with specific stages based on the experients' descriptions. Subcategories were then composed of bins that emerged as the data were analyzed.

The second conceptual cluster was composed of data relating to interventions as defined in the framework. The major predetermined categories included actions and impact. Again, a further division of each was required. Actions were divided into subcategories of "helpful" and "not helpful". Impact was divided into "impact of actions" and "impact of near-death experience". These subcategories were then divided into bins identified during data analysis.

To derive the bins, the investigator identified relevant statements in the responses and looked for distinct types of concerns that could be classified or catalogued. Coding was based upon the language structure of the response. The investigator read the response and decided into which category it best fit. To ensure trustworthiness, the investigator coded what the respondents said, without paraphrasing. Additionally, coding and classification were reviewed by peers to test for congruence and confirmability.

When a response could not be placed into an existing category, a new category was developed. With the addition of each new category, the previous categories were reviewed since

previously categorized data may have actually fit better in the newly defined category (Fox, 1976).

Miles and Huberman (1984) indicate that bins may be dichotomized into positive and negative ones. This was implemented in the analysis of "impacts of actions".

Coding Criteria

The third element of content analysis is the development of coding criteria. This requires a systematic classification scheme. The purpose of the definition and rationale of the scheme is to eliminate coder judgment and assure that similar data is coded in the same way (Fox, 1976). Definitions were developed to assure that data were grouped appropriately and that data within any subgroup had similar meaning. Secondly, categories, subcategories, or bins consisted of two or more units of analysis. When only one unit of analysis was found to fit a classification, the existing categories were reevaluated and reviewed to determine if the content could be included in an existing category.

Categories were evaluated for homogeneity, inclusiveness, usefulness, and mutual exclusiveness. These attributes are desirable to ensure that the classification system represents the dimensions in the actual content of the responses in a meaningful and reliable format (Fox, 1976).

Trustworthiness

Measures to ensure trustworthiness of the research study included:

1. Standardized interview questions designed to be open-ended rather than leading statements;
2. Recording and transcribing of interviews to prevent the investigator from relying on memory or personal interpretation of participants' responses;
3. Coding of responses based on actual statements, without paraphrasing by the investigator;
4. Verbal flexibility of the coder to allow responses that represented different ways of saying essentially the same thing to be placed into one category (Fox, 1976); and
5. Task compulsivity to search through all categories to find the most appropriate placement for each unit of analysis (Fox, 1976).

Summary

A descriptive/exploratory study of NDE experients' perceptions of interactions and interventions related to their NDEs was completed. Data were obtained by using recorded interviews of responses to standardized, open-ended questions. The sample consisted of eight adult subjects selected for their NDE. Demographic data were analyzed to describe the sample. Content analysis was the primary method of data

analysis. Responses were initially categorized by statements within the concepts of interaction and intervention and their subcomponents. Further subdivision into bins occurred as the data were analyzed.

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

Chapter four presents the data obtained in this qualitative study. Demographic data and characteristics of the sample are included. Categories and subcategories identified from the data and a description of the properties of each are presented.

Description of the Sample

The sample consisted of eight participants, four women and four men. All were Caucasians; seven were born in the United States and one was born in Egypt. Their ages ranged from 28 to 68 years of age with a mean of 47 (Table 1). One participant was married, three were remarried, and four were divorced. Years of education varied: one had a 6th grade education with a GED and 3+ years; one had a 10th grade education; one had 12+ years, two had 14+ years, and three had 20 years or more. The religious preference of four of the subjects was Protestant, one was Fundamentalist/Evangelical, and three listed other preferences such as "Christianity", "Spiritual", and "just God". Of these three, one had been "raised Catholic", one had a Protestant background, and the

Table 1

Summary of Demographic Data

Subject	Age	Sex	Years Since NDE Occurred	Time to Obtain Info or Disclose Full NDE (years)
1	M	47	16	1-2
2	M	68	12	3
3	M	47	9	6 weeks
4	M	49	7	1-2
5	F	42	21	8-10
6	F	28	4	3
7	F	48	22	10-12
8	F	48	>11	8-10

third had been exposed to various churches during childhood. Their occupations included minister, registered nurse, computer operations manager, PhD. candidate, anthropologist, office supervisor, and retiree.

The NDEs in this study occurred during diverse circumstances such as a miscarriage, illness (Guillian-Barre syndrome), routine surgery, motor vehicle accident, drug overdose, and cardiac arrest. The time elapsed since the occurrence of the subjects' NDEs ranged from 4 to 22 years (Table 1). Five informants indicated they had no knowledge of NDEs prior to their experiences. Three stated they had a

vague idea: two had known of someone who had an NDE and one subject thought she had seen a movie or journal article at some point before her experience. All eight participants stated they had explored NDEs to some degree after their own experiences occurred. Six had seen or read Moody's (1975) first book. Six subjects had also talked with at least one other NDEr, but three of these six indicated it was on a limited basis (on only one or two occasions) and a fairly brief exchange. Finally, five subjects stated they had read or "scanned" at least one other book on NDEs and two had talked with several other experients.

During the interviews it was revealed that there was much variability in the time span between the occurrence of the NDE and the time subjects were able to tell their complete experiences or obtain information (Table 1). The time span was less than one year for only one subject. This subject had the opportunity six weeks from the time of his NDE. Two participants stated it was approximately 1-2 years before they related the whole experience to someone, and two other subjects stated it took three years to find someone with whom to share it. Of the three remaining subjects, two indicated an 8-10 year time span. The third described ten years of bewilderment before finally reading an article that named the phenomenon, and another two years before finding someone to listen to full disclosure of her experience.

All subjects had a minimum of two of the core elements of NDEs described in Chapter II. One subject experienced aspects of all of the elements, while most of the subjects described aspects of 5-8 characteristics. The elements will be discussed briefly to summarize their experiences.

Selected comments from interviews are presented throughout this chapter to illustrate various concepts. The subject's letter code follows each statement.

Separation of Mind From Body

All eight subjects related a separation of mind from body in which they were suddenly aware of looking at things from a vantage point outside their physical bodies or "felt" separated. One subject indicated he was aware of being in "another realm," separated from his physical body, but did not view his body. The other seven subjects saw their physical bodies below and also described sensations of "levitating" upward or floating above their bodies. All of them also spoke of wondering why the people below, working on them, were so concerned. Some of their thoughts included:

> Why are they wasting their time? I don't want that old body anymore. (A)
>
> I was really as if I'm smiling at these people who are doing a lot of effort. It doesn't need to be done. (B)
>
> I was trying to tell my friends, you know, "Calm down. It's okay. I'm okay" and I was trying to shake them and tell them that I was okay.(G)

Sense of Being Dead

Six participants described some type of knowledge relating to being dead or dying. One stated she thought "Oh Wow! I must be dead" and was fascinated watching all the events around her. Two individuals stated they thought "it's over" or "I figured I was probably going to die". Three had a sense of a barrier or realm that they knew if they entered or crossed it would mean they could not return. One person described this aspect as being "in the cusp of death".

Sense of Overwhelming Peace, Love, and Painlessness

This is the second characteristic which all eight subjects described in their NDEs. Great peace, calm, and painlessness were related by all eight, and five experienced the love which they said is beyond anything imaginable or comprehensible on earth. This love evoked strong emotions from some individuals as they attempted to explain it. Upon return to the body, some related a sudden, and rude awakening to severe pain.

Entrance into Darkness or a Tunnel

Five subjects experienced some variation of this element. One person saw the tunnel and knew if she entered it, she would not return. Another individual spoke of "floating down a long hall that was all lit up with this bright light". One man was suddenly and instantaneously transported "like a whoosh, maybe 10,000 miles away". He could see both 1) the

hospital room "far away, the same size it did exist" and 2) his deceased relatives at the same time, although he was aware the two existences were far apart. Another subject heard an "incredibly loud, vibrating...really unpleasant, electric buzzing" as she was being rapidly spun around, just before she began floating upward. The fifth person described that during his first NDE he felt as though he had "broken through something to the other side". In his second NDE three years later, he entered a "blackness, absolute dark, blackness" during a negative portion of that experience.

Another aspect of this element is an incredibly bright light. Six of the study participants encountered this light which was described as "brighter than the sun", a brilliant light that did not irritate the eyes and cast no shadow, and a warm, glowing, loving, peaceful white/gold light. One woman experienced a light that was an electric blue incensified "25 times the brightness."

Encounter with Other Beings

Three experients met other beings. One man met his deceased parents and was introduced to three siblings who had died before he was born. Another man was met by beings "like elders" whom he did not recognize. The third person was "enfolded by this being, welcoming [her], accepting [her]" and was aware of several other beings around her who also projected total love and acceptance toward her. Communication

in these events was described as similar to a "mental telepathy" or instant "knowing" between beings. In addition, two subjects described voices that spoke to them, although they did not see the beings who spoke.

Encounter with a Supreme Being of Light or Deity

Two people met a Being of Light whom they knew to be God or Jesus, or as described by one person as "The Supreme Being". Not only did they see this deity, but they communicated with it. The first person described the exchange as "thought communication". The second subject explained that it was non-verbal communication that was "from the heart or soul" to the Being. This man stated "My heart would ask [anything]. I couldn't stop it....it's just total nakedness in front of Him..." He perceived that the Being was Jesus Christ and indicated that answers were immediately made known to him "in [his] heart". Two other experients felt that God was part of the presence all around them. One individual interpreted the voice he heard as that of Jesus.

Life Review

Only one subject had a type of life review in which he felt he was "encapsulated" by "the corridors of [his] mind". He explained that this was a review of the ideas or things in his life, such as racial prejudice, which he had considered and chosen to either believe or reject. He was also shown biblical events such as the crucifixion of Jesus, and later

saw what his own future would be like. He was not allowed to remember the future details, but recognizes things as they come to pass in his life now.

Sense of All-knowing

Five experients related this element during their NDEs. They described such things as "understanding how it all works", " the meaning of life", "the Divine Order of things", "the rules of the universe", "the do's and don'ts" for living, the ability to know anything they wanted to, as well as the instant reception of purposive knowledge or specific truths. While some of this information could not be brought back, some of it was retained to a certain degree, though the clarity was not the same as during the NDE.

View of or Entrance into a Beautiful Place

Four participants experienced some aspect of a "heavenly realm" that included joyous rejoicing and singing, but not as is known on earth, music or pleasing sounds unlike any heard before, and vibrant colors beautiful beyond description. One man was shown two cities, one of which was "endomed". He thought they represented future cities here on earth, or that the "endomed" one might have been "a heavenly city", but was unsure how to interpret what he saw.

Return to Body

All eight participants related a rather sudden return to their bodies. Two were just suddenly back in the physical

body and immediately aware of pain. One woman chose not to enter the tunnel but to return, and she suddenly was looking at things "back through the eyes in [her] head". Two of the experients described a more traumatic return, although it was not physically painful for them. One woman was "thrown back...with a thud" and was suddenly choking and gasping for air. The second was "forced" to return by the resuscitation efforts on his physical body. Three subjects were either told or somehow knew they were to return. One of them had a severe head injury and felt himself slowly going back down until there was a sudden "black nothingness" when he entered his unconscious body. Just prior to his return he was given reassurance that he would be all right.

Negative Near-death Experiences

Only one person encountered a negative aspect, which was at the beginning of his NDE. Initially he went into absolute blackness which he called hell because everything that he personally feared, for example snakes, was in there with him. He stated he was "threatened [and] tormented by fear", and felt as if he was totally "alone and separate" with his fears surrounding him. He felt himself going deeper and deeper into a cold darkness, which he stated was "a spiritual coldness". Although he had not believed in God before this, he cried out to God to help him and was instantly in "the womb of light itself" and felt peace, warmth, and love. The remainder of

his experience involved many of the more pleasant NDE elements described earlier.

Results

The first research question sought to determine the characteristics of the interactions that NDE patients have with health care professionals and significant others concerning disclosure of the NDE. During data analysis, communication was identified as the crux of what was described in the interviews, with perceptions as an integral part of communication.

Communication Process

Data bits that involved the disclosure or sharing of the NDE were placed into this category. The general order of the steps in the communication process was determined during analysis of the first interview, and each subsequent interview was compared for consistency to the pattern. Not all of them followed the exact same order, but many similarities were seen. Those that deviated suggested the existence of certain dynamics that involved decision windows and feedback loops throughout the communication process.

Communication is a complex process. There seems to be two levels of communication, one that is the immediate or ongoing interactions occurring minute to minute, and a second level that evolves over a lifespan. In the communication observed in this study the first level demonstrated the

characteristics King (1981) used to describe communication. Single interactions as they occurred were personal, situational, perceptual, and dynamic. These daily communications, when interpreted together over time, led to the development of the individual's overall communication pattern. This second level suggested an evolutionary characteristic of communication that was influenced by a person's past experiences, and developed through multiple interactions over time. Both levels of communication were intertwined throughout the communication process.

The steps of communication included perceiving the NDE, having an urgency to tell, sharing freely, strategizing, seeking knowledge, perceiving actual response, evaluating value of response, regrouping, editing, testing, evaluating response to testing, insisting/persevering, and sharing for a purpose (Table 2). The first research question for this study focused on NDErs' interactions and their perceptions of how others reacted or responded to disclosure of the NDE. During data analysis, three subcategories of perceptions were identified, which were perceptions of the near-death experience, preconceived perceptions or expectations, and perceptions of responses to disclosure of NDE. All three seemed to be an integral part of the process and are addressed as they fit into the communication process.

Table 2

Steps of Communication Process

Communication Process
Perceiving the NDE
Having an Urgency to Tell
Sharing Freely
Strategizing
Seeking Knowledge
Perceiving Actual Response
Evaluating Value of Response
Regrouping
Editing Details
Testing
Evaluating Response to Testing
Insisting/Persevering
Sharing for a Purpose

Perceiving The NDE

This was the first stage of the communication process and was the perspective from which NDErs began communication. Perception of the NDE involved the experients' thoughts and emotions concerning the experience itself and played a major role in determining what communication would take place. The perceptions of the near-death experience established the mind-set of the experient after undergoing a highly charged experience and influenced how the subjects felt about the experience at the time it occurred and how they currently feel. This subcategory included the perceptions that the NDE was positive, wonderful, real, natural, and an integral part of the whole.

Positive. All eight participants affirmed that the NDE was a positive experience and none categorized it as negative. They also indicated they felt fortunate to have had such an experience. Even the individual who had a partial negative NDE indicated that while that was indeed painful, the positive experience that followed outweighed anything else.

> I felt and experienced a lot of positive....I was happy that happened to me. (B)
>
> Oh it was positive! It was definitely positive. (C)
>
> It was a good experience. (D)
>
> The NDE was nothing but a positive, beautiful, pure experience. (G)

Wonderful. Similar to the positive, this described the joy and happiness NDErs felt then, and continue to feel about the experience, even more than 20 years after it occurred in some cases. Experients were radiant with expression as they described their wonderment and joy.

> This was SO wonderful....the most wonderful news! (A)
>
> That was the **highlight** of almost my life! ...the most **joyous** time I ever had! It was very joyful, very pleasant. (B)
>
> It was just very special something like that happened to me. (F)

Real. All eight subjects strongly asserted that the NDE was real, and in no way a dream or hallucination. Even those occurring more than 20 years ago, were as vivid today to the experients "as if it happened this morning." There was detail

and clarity about the NDE and it was commonly described as an unforgettable experience.

> I felt this [NDE] is a reality existed as we are talking now. I have no doubt of what I saw or felt. I am 100% sure it is not a dream. (B)
>
> It sticks with you when it happens to you. You don't forget it. You know it's different [than] a dream. (D)
>
> I remember looking down just as vividly as anything. That really stayed with me. (F)
>
> I'm clear about what I experienced. I've never questioned it. (G)
>
> Dreams are kind of cloudy, also conceptually vague. [The NDE] really comes across different, with a lot of detail, real clarity. (H)

Natural. Despite the descriptions of being out of body, and encountering some elements that were perceived to be unlike anything here on earth, NDErs repeatedly stated that the NDE felt "so normal." They related that there was no fear, and at the time it seemed to be more right than the physical existence here on earth. The two subjects who had out of body experiences, but did not go beyond that indicated that it was so natural and something they thought everybody experienced. It is noteworthy that these subjects did not think it needed to be mentioned to their doctor or nurse because they thought "Well, of course they know about this." One lady said it would be like "saying my toe hurts when somebody just stepped on it. You know **they** know it hurts so you don't have to say so."

> ...it was just such a normal thing. It was a normal part. It was so normal. It didn't seem like anything strange. It didn't seem strange to me at all. (A)

> I didn't know it was unusual. I didn't know that it was something everyone didn't go through. (C)

> It just seemed so totally natural. It seemed like just a part of the situation and it didn't seem like something that needed to be mentioned....I thought that's what happened to everybody....I almost thought that was the normal time and all the other [surgeries] were the weird ones....It just seemed very, very natural. (F)

Integral Part of Whole. In addition to being natural, the NDE was also described as "part of everything else that was happening to me." Each person was affected by the experience and conveyed that it was simply part of them.

> This was as much an integral part of it as everything else. (C)

> It's who I am now; it's who I've been for the last 16 years [since NDE]. (E)

> It was just a part of my life. (F)

These perceptions of the NDE had a strong influence on the communication process. The joy, the excitement, and the meaningfulness of these perceptions led to the sense of urgency to tell. These perceptions provided the motivation and energy for disclosure, as well as a deeply felt need to communicate.

Having An Urgency To Tell

The second step, urgency to tell, stemmed from undergoing an event that made a significant impression upon

the individual. It involved both the excitement of heralding wonderful news that was felt to have value for everyone, and the compelling need to talk about an event that was too emotionally charged for the individual to hold inside. One woman described her excitement and stated "All I wanted to do was share the information. This was so wonderful and I wanted to share it with everybody! I thought everybody should know....I felt it would help them." One subject was so overcome with the experience that he went to the newspapers and churches to spread the news of what he had seen and learned during his NDE. Another man spoke of the difficulty of trying to "keep such excitement suppressed". The desire to share the wonderful news and the need to talk about the experience was a recurrent theme throughout the interviews.

> I wanted to share it so badly. I had it all inside....I was trying to give them the most wonderful news. (A)
>
> If you have...a joyful feeling wouldn't you like to share it with others? (B)
>
> I was eager to talk about it. (C)
>
> ...first thing I wanted to do is tell people. I just went crazy with it. I went down to the newspaper. I went to some churches and told them....I had SEEN something!...This was peace. I felt very glad to be back and I just thought I could hand it out like you did money. (E)

Sharing Freely

The third step, sharing freely, was characterized by experients not being afraid to relate their experience. There was an innocence and vulnerability at this point because they were unguarded and not prepared for anything but a positive response to disclosure. Subjects indicated that they "volunteered it" or spoke "without prompting" and were not at all afraid or uncomfortable talking about their NDE. There was some variability in the informants related to this step. Two subjects felt it was a "sacred" experience and had anticipated difficulty in conveying the totality of the NDE to others. They indicated however, that they had wanted to talk freely about the entire NDE at this point to people close to them. These two subjects represented the more conservative aspect of the spectrum. Several subjects described this step as an eagerness to talk freely about it with their family, friends, and caregivers. They inferred that they expected others to be warmly receptive of the "wonderful news" and that they would not have had any qualms about telling most people. This group represented the middle range of the spectrum. The least inhibited was the man who went to the newspapers and churches to tell everybody. He demonstrated no difficulty telling anyone about his NDE. For most informants, this stage was short-lived and altered by the responses to their initial attempts at disclosure.

> The first time...I just kind of padded on....I did it without prompting or anything. I tried to explain the whole thing from start to finish. I wasn't afraid to talk about it. I wasn't afraid he wouldn't believe. (C)
>
> I started telling anybody that would listen. (E)
>
> I wasn't afraid to talk...I just felt that was the way it was and I shouldn't have any reason to be afraid of it. (H)

Strategizing

Step five, strategizing, refers to the planning of conscious decisions about disclosure of an NDE. Comments made during the interviews suggested that there were preconceived expectations that were inherent to this stage and that influenced decision-making about disclosure. Preconceived expectations were perceptions or thoughts the individual had about a person, a professional role, what society might think, or how others were expected to act. Preconceived expectations were based on a culmination of an individual's life experiences, prior relationships, and cultural values. They influenced the NDErs' communication of their experiences at nearly every stage of the process. Data bits were clustered into three major bins under this subcategory: person, role, and society.

Person. To know or interact with anyone means that some opinion or perception has been formed. Experients identified preconceived expectations for family, friends, and health care professionals based on the previous personal

communication and perceived characteristics of the other persons. For example, a physician who was perceived personally to be "a fanatic Moslem" was identified as someone not to tell. Many informants indicated they thought their families would believe them and could help in dealing with a new experience. Preconceived expectations about people determined the importance of the listener's response and the degree to which experients were affected by that response.

> I thought of all people, I could talk with him [neurologist] and he would understand because here-to-fore...he seemed to understand [my symptoms] better than anyone else. (A)
>
> I felt he is a fanatic Moslem and wasn't receptive to hear or discuss anything. (B)
>
> ...my family, I thought, would have been the most supportive (C)

Role. Everyone had their own expectations of health care professionals and others such as the clergy. One subject who wanted to share the spiritual truths he experienced expected that churches would naturally be interested and excited to hear what he had to say. One woman held doctors in high esteem. This influenced her decision to tell her doctors first, and caused her distress when they did not respond as expected.

> I had doctors on a pedestal....they were supposed to be all-knowing, all-caring....He would know about this. He would do everything right. (A)
>
> I went to the churches with it. I was expecting they would want to hear. (E)

Society. Several subjects indicated that they felt death, the idea of being near death, or dying and coming back to life were simply taboo subjects. The elements of the NDEs, such as being out-of-body, meeting a Supreme Being, or talking to deceased relatives were thought to be beyond the scope of what most people could believe. Some subjects felt they would be accused of sensationalism, making it up, or being mentally unbalanced. The preconceived perceptions about society and what people might think fit into several areas of the communication process such as the decision whether to tell or not and how much to tell. In some cases the notion that "no one would believe it" blocked disclosure until the experient was later drawn out or encouraged to speak of the NDE. Another example is the subject who spoke of the impact of the NDE. She had never told her family or anyone else before this interview because she felt people would not believe her and society would "ostracize" her if she told. In the strategizing step, preconceived perceptions about societal response affected the individual's decision concerning who to tell and who not to tell.

> It's like it's a taboo [subject]. (A)
>
> Because I think people would not understand....either laugh at you or say that guy is crazy or accuse of other things. (B)
>
> It seems to be a pretty taboo subject....It's beyond the realm of what people believe to be rational....I wouldn't even dream of telling anyone about this because

> I think they would just completely freak out....I would be ostracized from society for even admitting to this sort of thing. (C)
>
> ...they'd just think I was mentally sick or on drugs (E)
>
> ...I felt that people would cart me away if I told them this. (G)

Strategizing was evident at this point in communication, but the focus of strategizing was who the experient would most enjoy sharing the NDE with or who would be most happy to hear about the NDE. As experients were in the later stage of regrouping after initial disclosure, there was a feedback loop that returned to strategizing. Disclosure became more tentative and the focus of strategizing became who was trusted, knowledgeable, or accepting enough for the experient to talk with about the NDE or who needed to be told.

To clarify the strategizing subcategory, data units were further divided into three bins: who to tell, who not to tell, and when or where to tell.

Who to tell. Selection of who to tell was based on such things as the prior nature of communication with an individual, preconceived expectations, perceptions of caring and accepting, intimacy, similar circumstances, as well as opportunistic factors. One woman selected a nurse with whom she felt close because of the personal care the nurse had administered to her during the woman's hospitalization. It was often relayed that the experient selected "someone I'm

very close to" or a "good listener." Sometimes the selection was opportunistic, such as the first caregiver the person encountered after the NDE. The primary element seemed to be selecting someone the experient felt was caring and trustworthy.

> I tried the doctors first. They were in charge of me...and they should hear it first and first hand....My family doctor came in [first] the night it happened and...indicated he knew a little bit of what took place, so I started telling him. (A)
>
> I decided to talk to the nurse...I had gotten very close and comfortable with this nurse. Some were much more caring. She's the one who made my bed and helped me with the urinal and stuff like that. (A)
>
> I did have a lot of trust with her. That is number one. (B)
>
> I told my mother because she almost died [once]. She would be the person I would tell something like that to....simply because I'm very close to her. (C)
>
> It's easier...talking to somebody that had the same thing happen. (D)
>
> I couldn't tell just anybody. It had to be somebody really close to me....Just his acceptance of me and the friendship bond...made it safe for me to talk to him about it....He really opened up to me and shared and I felt like I wanted to share my experience with him. (G)
>
> He came across as someone that you can really trust as an individual, but also he told me [he had a kind of experience after his accident]. I just felt a rapport with him quickly....I felt more open talking with people who had the same experience. (H)

Who not to tell. This bin was generally comprised of people or groups that the individual was not close to. Some experients stated they did not tell a member of the clergy

because they were "not close enough to discuss that" or were not attending a church on a regular basis. In addition, one woman did not think the clergy would know anything about it. Health care professionals were not always seen as being open to the experience and therefore were not told.

> ...I was pretty sure the clergy didn't [know about it]....we didn't really have a church here...nothing steady. (A)
>
> I'll never tell anyone that I don't trust real well.... I wasn't close to any...clergy, not close enough to discuss that. (C)
>
> I didn't even try to tell health care professionals "No!...I Knew better."....[sometimes] I feel their motivation is curiosity [so I won't tell them]. (G)

When and Where to tell. The third bin under strategizing involved planning the environment or circumstances for the optimal time of disclosure. Considerations involved privacy, a minimum of distractions, and the appropriate time and place.

> I hung around until everybody else left the room. (A)
>
> You really have to judge whether people are in the right frame of mind...whether it's a good time to talk or not. You have to have a minimum of distractions...you don't talk to them at a restaurant or whatever. I found the best way to talk to people about the subject was one on one. (H)

Seeking Knowledge

Seeking knowledge was the next stage of the communication process. It was characterized by attempts to learn if others knew of, or had experienced such an event.

Most experients were searching for information from the very beginning and were eager to learn more about what it was that had happened to them. Often communication was initiated for this reason. The desire for information also influenced who was told, based on how knowledgeable the person was perceived to be. Often, NDErs began their search by asking questions about their medical status, hoping it would lead to the opportunity to talk about the NDE.

> I was looking for knowledge. I couldn't believe that something so wonderful hadn't taken place before....I went...to a series of lectures at our church...out of curiosity...because I wondered what they had to say about death and dying and how it happens. (A)
>
> I tried to let them know I know I had a cardiac arrest. Would they confirm it... (B)
>
> ...beyond asking...it was the feeling that she understood and also getting more information from her about the whole thing. (H)

Perceiving Actual Response

Step six, perceiving the actual response, involved the experient's beliefs about the way listeners reacted or what the experient believed the listener thought about the information given at the time of disclosure. Probing questions were asked in the interviews to try to draw out how subjects arrived at their perceptions. All subjects could readily state what they perceived the other person thought, but it was harder for them to explain the exact cues, behaviors, or actions that led them to their conclusions.

This implies a subtle automatic communication process that operates almost on a subconscious or subliminal level. The perceived responses determined the amount of information that was exchanged. Data bits fell into two bins: 1) Non-Acceptance which tended to have responses that were negative or not helpful, and 2) Acceptance, which had mostly positive responses.

Non-Acceptance

Non-acceptance was defined as the inability of the listener to allow disclosure of an NDE or to give credence to the account of an NDE. Some listeners sent the message "I can't listen to you." They would not listen to what the experient wanted to tell, but did not necessarily convey the idea that something was wrong with the experient's thinking. Other listeners conveyed the message that there was something wrong with the experient. The account of the NDE was not accepted as reality or an event of importance. Perceptions identified under non-acceptance included concern for loved ones, discomfort, fear, indifference, disbelief, doubt of NDEr's rationality, and condescension. These perceptions tended to block or inhibit further disclosure.

Concern for loved ones. Sometimes concern for loved ones was described in terms of fear, but the cause or motivating factor behind the listener's response was clearly a concern for the well-being of the experient. One man who

was severely injured and in intensive care indicated his family was afraid he would overdo his activities and so they would not let him talk about it. Another stated her mother was concerned to "hear her daughter talking crazy." Often, the listener was perceived to be fearful or uncomfortable about nearly losing the experient to death.

> He just broke down and cried. He couldn't deal with the fact I'd almost died so then we just didn't talk about it. (C)
>
> I was pretty sick and she was still pretty afraid and wasn't ready to hear it. (C)
>
> It makes them uncomfortable to think of their mother being close to death. (F)

Discomfort. Discomfort was perceived as a listener response that indicated a listener problem or deficit. For whatever reason, the listener was perceived to become very uncomfortable. This reaction included perceptions that it was difficult for listeners to talk about death, the NDE made listeners aware of their own vulnerability, or as one man related "they did not know how to talk about it." Frequently, the subject was changed because of discomfort. Often experients perceived that a listener was uncomfortable, but were unable to discern the cause of the discomfort.

> [The doctor] seemed very uncomfortable with me talking about going out of my body and up near the ceiling....My family was disturbed if I started telling my experience. It was an uncomfortableness....When I would start talking about going out of my body and being up at the ceiling, that really bothered people. (A)

> It made him uncomfortable and he'd change the subject...so I didn't bring it up with him anymore. (C)

Fear. Fear occurred when experients perceived that listeners were frightened by unfamiliar material or by lack of knowledge about what had happened. Health care workers, when perceived to lack knowledge of the phenomenon, were also perceived to be afraid to discuss it. Family members were perceived to be frightened when they didn't know about the phenomenon. Some subjects indicated others displayed fear and anger when the NDErs account or beliefs contradicted church doctrine.

> I felt they (doctors) were afraid. I felt it was something he didn't know about, and he was uncomfortable dealing with it. It was like a fear of hearing about it. (A)

> ...others look some way as a strange situation they are scared to talk about it. (B)

> She was still frightened and didn't understand; it was just so alien to them. (C)

> ...in the case of religion part, fear and anger started coming towards [me]. (E)

Indifference. Experients sometimes got the message that the person just didn't want to hear about the NDE out of disinterest, lack of caring for the experient, or for unexplained reasons. A couple of subjects indicated the person didn't want to hear because they "did not care about me or anything else." Several subjects also noted that

health care professionals were just not interested, so the NDE was never fully revealed to them.

> Here I've got this wonderful news and nobody wants to hear it. (A)
>
> They didn't want to talk about it....She did not care about me or anything else. (B)
>
> I don't think [the doctor] would have cared much; I don't think he was interested. (C)
>
> She didn't care one way or another. (D)

Disbelief. There were two levels to this. First, there was total disbelief as described in "they were not even vaguely open to it." These listeners always found an alternate explanation or discounted the NDE. The second level was a skepticism that leaned toward disbelief, but allowed a slight possibility that the person might eventually be convinced to hear more. For example, family members were often perceived to be torn between the belief in a loved one's NDE testimony and a personal disbelief of the NDE concept. In some cases, such skepticism was converted to acceptance after listeners heard other cases of NDEs or read about the NDE phenomenon.

> Now my brother, I think he's still skeptical. (A)
>
> I find they don't believe it and as if they laugh at me. (B)
>
> She don't believe in this. (D)
>
> ...trying to describe it to the doctors...they were not even vaguely open to it. (G)

Doubt of NDEr's Rationality. Listeners were often perceived to question the NDEr's lucidity during the event or saneness in believing the NDE. The message that the experient was crazy or not reality-based was a common perception related by most of those interviewed. Some listeners conveyed that they believed that experients had dreamed it, imagined it, were hallucinating, or were "really losing it". This perception was a strong inhibitor of disclosure.

> They acted like I was off my rocker. That I was really losing it....They acted like I dreamed it. He used "imagine", "You imagine things happened." (A)
>
> They come back at me as if I am out of my mind. (B)
>
> They figured, this poor dude just blowed his mind...that I was crazy by man's standards. (E)

Condescension. Some listeners were perceived to minimize the importance of the information as if they were being told "just real minor things" or were "wasting [their] time". Condescension was also perceived to be involved in situations in which listeners seemed to convey that they knew the information simply could not be true and were waiting for the experient to realize that too, or that they were listening just to humor the speaker.

> He said "You're a sick little girl and strange things happen so don't worry." Just like "don't bother me with it." That's the message I got. (A)

> He treated me like I was trying to tell him my grocery list or just real minor things. It wasn't important enough to talk about and I was wasting his time. (A)

> ...other health professionals I feel more like they're condescending. (G)

> And then there were people like..."Oh, sure, sure. Well, groovy." (G)

Acceptance

Acceptance occurred when listeners conveyed that they believed, in varying degrees, what the speaker was saying. The listeners seemed to sense or believe that something had happened. During data analysis there seemed to be three levels or degrees of acceptance.

Level one. At this level, the listener was perceived to believe that "something happened" although not necessarily a near-death experience as the experient stated. This level of acceptance was the most tentative. Listeners did not deny that the person had experienced "something", but were very unsure or noncommittal about accepting the NDE phenomenon.

> I think they felt that something had happened. (A)

> They knew something had happened to me. She was there when some of it was happening. (E)

Level two. This level referred to a conditional acceptance of the experience as a kind of NDE. Experients perceived that acceptance occurred because listeners had some exposure to the topic before hearing the NDEr's account, or because they had heard of something like that happening to

someone else. One woman recounted that her husband had totally discounted it the first time she attempted to tell him about her NDE, but years later after he himself had a "brief out of body experience" he was ready and eager to hear more about her NDE.

> [The students] respond well because they've had a little background reading [before hearing NDEr speak]. (A)
>
> He said "Well, I've heard of a guy who had an experience like yours." Then he asked me more about it. (E)

Level three. At this level, experients perceived that acceptance was total and unconditional, regardless of whether or not the listener had ever heard of the near-death phenomenon or not. Listeners were "very accepting" and almost always wanted to hear more about it. One man summarized the attitude as "You're accepted. Period. **That's** unquestioned. And if you want to say anything, that's fine. That's accepted too." The account of the NDE was believed because that's what the experient said happened. In some cases, listeners evolved from the first two levels to the third level of total acceptance of the NDE.

> She believed me and asked me questions about it. She thought it was very interesting. (B)
>
> They're like "Wow that's really neat". Just accepting. They haven't put me down or been weird about it or anything. (F)
>
> [peers react with] for the most part fascination and wanting to know more. (G)

> ...was very accepting if I said it was the way it was and he said "Oh, okay." (H)
>
> She was interested and she wasn't skeptical. It was like "Well of course that happened. Tell me about it." (H)

Evaluating Value of Response

Step seven of the communication process is evaluating the value of the response. This stage was driven by the esteem or respect the experient had for the person or professional role of the listener. Preconceived expectations were influential in this step. Experients' perceptions of a person were an inherent part of this process. If the person's opinion was highly valued, then the response was more meaningful to the NDEr and vice versa. For example, if listeners were perceived to be lacking in knowledge or "skeptical about everything", their opinions had little impact. On the other hand, when one subject felt her physician had been highly knowledgeable and sensitive during her previous care, she was "absolutely crushed" when he cut her off during her attempt to share her experience with him.

> I had lost some respect in his ability...so I wasn't too concerned. (A)
>
> ...thought doctors are supposed to be all-knowing, all-caring, all-loving and want to do the best for you and that hurt when he wouldn't listen. (A)
>
> ...somebody who would be skeptical of lots of things anyway, and so I would discount their skepticism and say, "Oh well, that's the way they are." (F)

> He always took the hard-nosed approach to things and very skeptical, a jaded view of most things. I found the person does that anyway on everything. (H)

Regrouping

Regrouping, the eighth step of the communication process, was characterized by the experient reconsidering the events from the perceptions of the NDE to the options of what and who to tell. The data suggested a feedback loop that essentially returned to the beginning steps of the communication process. Experients lost some of their uninhibited feelings as they re-examined the communication that had occurred thus far. Individual reactions varied from trying again later, selecting another individual to tell, or opting not to discuss it any further. One woman decided the male doctors were "too bull-headed to listen" so she decided to "try the women [nurses]". This not only illustrates the regrouping stage, but also alludes to underlying perceptions of masculine and feminine characteristics and shows how closely linked perceptions are to the communication process. Some subjects also began to question themselves or the experience at this point.

> I thought "All right, if these men are too bull-headed to listen to me, I'm going to try the women." (A)

> I refuse to talk about it after that for a good long time. (B)

> ...then I might try again some other way, some other time. (E)

Editing Details

Step nine, editing details, was characterized by subjects limiting disclosure of the details and only talking about the "high points." This occurred without exception, after regrouping. The experients offered smaller bits of information and "watered down" the details they chose to disclose. One woman, who had freely talked about floating out of her body in her first disclosure, now edited it to "I felt kind of detached from myself". Another woman said at this point she only told her family that she "thought she had experienced death" and has never disclosed any further details to them.

> I only hit the high points...I really didn't give any details. I was cautious in my approach to other people. (A)
>
> There is a way of cutting it short. I limit it. (B)
>
> I told [him] briefly, real briefly...I didn't go into it. I said I felt kind of detached from myself and that was all I told him. (C)
>
> I [didn't tell] the details...just that I came very close to death. (G)
>
> I told them little pieces...(H)

Testing

Editing and offering smaller bits of information led naturally to step ten, testing responses, characterized by hints or statements intended to draw a response from the listener. When an experient made a comment such as

"something strange happened", it was a test to see if the listener would respond and open the door to further disclosure or if the subject was best dropped. Often, NDErs statements were subtle, or they would use questions such as "Did you see somebody come into my room last night?" or "What do you think about...?" One woman said if they responded to her comment about feeling strange, then she would say "Well I went out of my body". She felt this was a big step, although immediately after her experience she would have talked easily about going out of her body, seeing a tunnel, meeting a Supreme Being, and choosing to return. This illustrates how guarded she became through the course of the communication process.

> I got very guarded...I tested people. I would give them a little bit of information to see what their response was going to be. (A)
>
> You start testing them, how do they feel about... I like to confirm my feeling if they really are interested to hear. (B)
>
> Sometimes I throw out things to other people... and see what they say....especially after the first time, I was waiting for encouragement to tell. (C)
>
> It's how they respond to a comment...like [you] put [your] foot in the door. (E)
>
> I was trying to be fairly careful as to who I would talk to. If a person was willing, fine, if not I didn't push the information....I started off by asking [a question]. I was just going to see what she would say. (H)

Evaluating Response to Testing

Step eleven, evaluating response to testing, was characterized by the experient watching closely to see how the listener responded to a test. Almost every one of them described their alertness in gauging reactions, such as "I began to be more aware" and "I was watching her face to see if she looked surprised or shocked or something". Further communication was dependent on the experients' perceptions of whether or not the listener was open to further disclosure. Another common thread that was discussed as experients struggled to specify how they judged reactions, was that they had become aware of a greater "sensitivity" to people following their NDEs. They just "knew" if a person was sincere and worthy of trust for disclosure of more details. They had learned to trust this inner sense. One man explained that people had "a radiation of [their] feeling and [their] mind thinking" which he would sense regardless of whether or not it was consistent with the words spoken by the individual. Seven of the eight people interviewed described or alluded to this sensitivity.

> I was watching to see if they would be receptive to even just listen. (A)
>
> I was waiting to see...if they were not going to do any challenging...not make funny remarks. (B)
>
> I'm always still trying to gauge their reactions. (C)

> ...if [they] acted like they thought I was being stupid or something, I would shut up. (F)

Insisting/Persevering

Step twelve, insisting/persevering, described experients' continued attempts to convey their NDEs to others and their ultimate refusal to repress the NDE. Insistence occurred at different time intervals for individual experients. Some subjects tried to tell more than one person in a period of one or two days. Insistence was also repeated attempts with the same person. It occurred over a few days or weeks, or even over several years. One woman, who had attempted unsuccessfully to tell her mother at the time the NDE occurred, finally approached her mother again, more than 12 years later, and insisted that she listen to the whole account. Another subject, whose NDE was four years ago, indicated that her family had been unable to deal with it at the time so she "tabled it", but plans to bring it up again "sometime" in the future. In many ways, insistence may be associated with, or driven by, the irrepressible nature of the NDE itself. Subjects who described more involved NDEs, seemed to be more adamant about their NDEs and less inclined to accept passive explanations, withholding of information, skepticism, or challenges to the validity of the event.

> I did mention, it several times. I threw it back at them. I would remind them "I tried to tell you about it the other day, the experience I had." (A)

> I told her again [several years later] there's something I want to tell you and you're going to think it sounds really strange and that's okay, but I want you to hear if from me. Just listen. (A)
>
> She came again a day or two later and I confronted her. (B)
>
> This was the same day that I tried to tell all three of them about it. (C)

Sharing For A Purpose

The final step in the communication process was sharing for a purpose or if requested. It incorporated many of the previous steps. The experient still strategized, edited, tested, and evaluated responses. But disclosure occurred more for the needs of other individuals and less out of the experient's need to tell. At this point most subjects seemed to have "accepted that [the NDE] happened" and had banished self-doubt or questions about the validity of the NDE. Experients indicated a need to disclose it in a personal relationship because the NDE is an integral part of them. As one woman described it "If someone seems to be becoming a close friend or if I'm getting into a relationship, I will tell people and if it's going to scare them away, then I really don't want anything to do with them because...it's...a big part of what I'm all about." Acceptance of the person must include acceptance of their NDE.

NDErs in this stage, however, primarily used the experience to help others. This involved sharing on an

individual basis to comfort someone dealing with a loss or afraid of dying, or on a larger scale through seminars, on television programs, or to special groups. One subject stated "I decided to talk to you because I think patients need people that understand. They need to know it's safe for them to talk about it." Most of the subjects expressed a motive with the desire for more widespread knowledge and understanding of the near-death phenomenon by health care professionals, clergy, and the general public. One man summarized "the thing that makes it worthwhile [to tell about it]...is that it gives some people some hope."

> I felt...what I had experienced...would help [people]....if I run across someone who's really having a hard time, especially after the loss of a loved one, I will tell them that I've died twice and I had an experience which really helped me out tremendously and if they're interested in hearing it, I'll be glad to talk with them about it. (A)
>
> ...I sometimes talk to nursing students, classes. (B)
>
> She was afraid of dying...I told her it's beautiful, that I'd been there, don't be afraid....I told her what happened to me...it did comfort her. (D)
>
> I sat with a young boy who was dying...discussed my experience [with him and family]....in my work with dying patients...it helps the family and the patient when we talk about it. (F)
>
> I freely shared it with [a man afraid of dying].... Usually it's their fear [that leads me to tell non-NDErs]. (G)
>
> Some people want to know for personal reasons, a loved one dying or something...or they just wanted to know more. I would just say my feeling about the situation. They shouldn't be afraid to die....Often people would

> have problems...we'd sit down and talk about how they felt about their problem. I say "I've had some experiences if you're interested, I'll tell you." (H)

Patterns of Communication

The stages of communication evolved from the affective domain to the cognitive domain. The initial communication was from a strongly charged "feeling" or affective perspective that involved urgency and unconstrained disclosure of the NDE. Communication evolved to a more "thinking" or cognitive perspective that had been tempered through the communication process. The end result seemed to be selective disclosure based on more objective and purposeful decisions.

Not all experients related the exact same pattern, though all of the elements were the same. The data suggested that there were some decision windows throughout the communication process where experients made choices about whether or not to tell, who to tell, how much to tell, and considered what their options were at that point. The first window seemed to be immediately after the perception of the experience. The first decision was whether or not to tell. Even though the news was exciting and joyous, one man decided that no one would believe him and chose not to tell. Another subject wanted to tell, but was prevented from it by her physical condition and the bustle of activity around her.

Within a few hours, she became introspective and no longer wanted to talk about it. In these cases, the window closed at the very beginning of the process. However, the window can be reopened at a later time. Several other reasons not to tell emerged from the data and are summarized in Table 3.

Barriers/Reasons Not to Tell. Experients identified several barriers to disclosure. NDERs were highly sensitive to doubts, negative responses, or fear of disbelief and were easily blocked from disclosure in this manner. Some NDErs stated the experience was "too personal" to share with others. Physical barriers, such as pain, exhaustion, heavy medication, or the need for an emergency procedure were cited as reasons that prevented disclosure. Some subjects indicated that they did not realize what had happened to them so they didn't initially talk about it. They either thought it was something that happened to everyone, or didn't think it was an NDE because "it wasn't a classic" one with the tunnel. Another barrier to telling was that other people, especially health care professionals, were so busy, or had time limits, so that experients felt there was no time to talk to them about the NDE. A very real problem also existed in the difficulties of trying to portray an experience that was "beyond description". Most subjects felt inadequate or frustrated in trying to explain things for which "there are

Table 3

Barriers/Reasons Not to Disclose NDE

Barrier	Subject	Comment
Fear of Negative Responses	B:	As soon as I feel there is doubt I reserve to silence and quit. I don't feel there is a need to convince anybody...I'm not interested in getting in a debate or to [have someone] investigate what I'm saying is correct or not.
	G:	It is a risk, each time...I don't know how the person will react.
Personal Nature of NDE	B:	I feel it is more personal experience than a publicity one.
	C:	I can't tell anyone I don't trust or am not close to.
	G:	It's too personal for me to talk about to most people.
Physical Barriers	D:	They took me down to the operating room so quick, I couldn't....They had me drugged up so bad I'd fall off to sleep before I got a chance to tell him.
	G:	I wanted to tell, but I couldn't cause I was choking at the time and couldn't breathe.
	H:	A practical problem was I had such severe headaches for a few months...I was in so much pain. After that it was easier and I was able to talk more about it.
Lack of Knowledge	C:	I didn't think it was a near-death experience because there was no tunnel with the light at the end of it...
	G:	I did not have a classic NDE like all these people and the tunnel.
	F:	I didn't know it was something unusual.

Table 3 - continued

"Busy-ness" of Others	B: I think he was so occupied. He never did ask any questions.
	E: They have time limits...only talked a few minutes to me.
	H: The problem with the hospital is that people are tremendously busy. The nurses were so busy. I never had anybody come by and sit down and say "Well how are you feeling, what's going on?"....The doctor is so busy, he has just so much time to see all his patients.
Ineffable Nature of NDE	A: There are no words to describe how it felt or what it was like.
	G: I don't feel comfortable talking to people who have not had at least an out of body experience. It's very frustrating. I feel inadequate that I'm not able to describe it. It's almost impossible to put into words. The words don't exist.
	H: I felt more comfortable talking with [NDErs]...other people really can't relate to it very well...95% of the [non-NDErs]...didn't know how to talk about it and there was no communication. There's a mechanical problem...with the need to translate.
Miscellaneous	C: I just didn't know how to talk to [the doctor].
	D: I was going to and then he got talking about something else and I didn't get a chance to.
	G: It is emotionally draining for me and it's difficult for me to come back and operate in the physical world.
	H: Eighty percent of the time when a health care professional came by I had 2 or 3 people who were sitting there...preferred to talk privately.

no words". Additionally, many non-experients were perceived as not knowing how to talk about NDEs. Other reasons not to tell included becoming emotionally drained by it or fear of"painting a wonderful picture" and catching someone who is vulnerable and who might decide to attempt suicide to reach that wonderful place. These barriers arose at various times during the communication process and most barriers could also be overcome, but that required positive encouragement from the listener.

The second decision window in the communication process occurred later, after initial disclosure. Depending on the perceived response, the experient had to decide again whether or not to make further attempts to tell, who to tell, and how much to tell. Some subjects chose not to tell at this point and essentially placed it on hold until a later date.

Those who chose to tell, entered into a feedback loop that involved reselecting who to tell, editing details, testing, and evaluating the response. This loop continued until the person chose to exit or the loop by "tabling" the discussion of the NDE or until they found someone to successfully share it with. Eventually, experients became more sure of themselves and of their experiences, obtained more information about the phenomenon, and became less dependent on the need to tell others. The end result was a communication routine that became comfortable to them. It

still involved decisions about how much to tell and to whom, as well as editing, testing, and evaluating. Overall the communication loop continued, but the experients moved from a perspective that was highly emotional, to a more objective, cognitive approach. Additionally, the reason to tell changed from a personal, searching one to a motive of providing comfort, meaning, and education for others.

Actions

The second research question asked what nursing interventions for NDErs were recognized by patients and what effects NDErs perceived from each. These actions and their impacts were the second focus in the data. In the study, actions were defined as deliberative nursing behaviors designed to identify and meet the patient's immediate need for help and, therefore, to fulfill the professional nursing function (Orlando, 1972). During data analysis this definition was broadened to include deliberate behaviors of nurses, other health care professionals, family, and friends. There were few examples of actions implemented by health care professionals. The interviews revealed that only three of the eight subjects had spoken to a nurse about their experiences, and those exchanges were very brief. The data analysis was enriched by including the actions of anyone experients had trusted and chosen to tell about their NDEs.

Actions fell into groups that were identified as helpful, not helpful, (Table 4) and a third subcategory identified from the data, which was self-help actions (Table 5). In addition, experients provided Recommended Actions that they would like to see added to the ones already identified as helpful. Actions were closely linked to the dynamics of the communication process. They served to either promote or inhibit further communication.

Helpful Actions

Helpful actions were ones that informants indicated made them feel better, facilitated comfort and ease in talking about the NDE, and were recommended ways to help new NDErs. Positive actions included just listening, showing interest, accepting, introducing subject, using humor, offering information, and sharing experiences.

Table 4

Summary of Actions that were Helpful or Not Helpful

Helpful Actions	Actions that were Not Helpful
Just Listening	Ignoring
Showing Interest	Discounting
Accepting	Denying Information
Introducing Subject	Medicating
Using Humor	
Offering Information	
Sharing Experiences	

Just Listening. Just listening was cited as the number one positive action and the first thing subjects recommended doing for NDErs. All experients mentioned frustrating experiences in which they were cut off after the first sentence or two about the NDE. The need to tell was deeply felt by these NDErs and they appreciated it whenever they could at least tell their experiences, even if the listener offered no feedback. "Good listeners" even coaxed some to tell more than was their intention. One man said the first person that he told his whole experience to was someone he never would have thought it would be, but "he listened and it was surprising that I told him some of the things that happened."

> At least they listened. Even if they didn't give any other feedback, it helped that they listened. (A)
>
> Just listening was probably what helped the most at first. (C)
>
> She was a very good listener. I felt like it was okay to talk about it. (F)

Showing Interest. The second action was showing interest. Experients primarily perceived that people were interested through non-verbal cues and because they asked questions or came back and discussed it more. When no interest was shown, the topic was dropped and the NDE was never fully disclosed. Along with listening, showing interest was an action that all eight subjects recommended

doing for other NDErs. The attitude that others cared, were open, or thought the NDE was a special experience was also part of this action. The verbal and non-verbal actions are well-illustrated in the following account by one subject. She was talking to a woman who "was sort of preoccupied up till that time....All of a sudden she got this totally different look and quit thinking about whatever else she was thinking about and she looked right at me and she smiled and she said, 'You've had one, haven't you?'", indicating a warm and excited tone of voice. The subject stated this was a "definite go-ahead that it was okay to talk about [the NDE]".

> She was very interested and asked a lot of questions. She was like she would like to learn from what happened to me so she drew me out. (F)
>
> ...their being interested and open [helps]. Some have responded like I was very special that happened to me. (F)
>
> He came back and started asking questions. They all gave me an indication they were interested in my experience. (H)

Accepting. The term "accepting" was assigned to another important set of actions. Acceptance was a very healing, comforting action. Since the NDE is integral to the person, it's acceptance was seen as acceptance of the experient. Accepting was inferred to go beyond listening and interest to believing the NDE occurred without doubts or arguments. This action helped subjects to normalize their experiences. Acceptance was an important part of recognizing what the

person had gone through and provided a communication bridge even when the events of the NDE were difficult to describe. It also helped some experients to accept the NDE themselves and to go on to learn about it and use it to help others.

> She didn't make me think I was crazy. She let me know it was okay to have experienced things like that. (A)
>
> She didn't put me down or anything. (F)
>
> They were very supportive, very concerned...felt very compassionate toward me. (E)
>
> They don't question whether it happened. They didn't harass me with questions, doubting that anything had ever happened. First they recognize what you've gone through, which is very important. They <u>accept</u> it. There's no argument. (H)

<u>Introducing Subject</u>. Many subjects were afraid or refused to bring up the topic, but when someone else did, it was easier for NDErs to talk freely. Experients indicated that even offering an opportunity to talk, such as "I see you weren't feeling too good today", or "what happened?" focused on the patient's perspective and invited disclosure. Questions that reflected knowledge about NDEs were also cited as successful ways that other people introduced the topic and encouraged disclosure. Examples of these included "Did you see a light?" "How high did you go?", and "Did you get a chance to see all the accident?". One man felt an immediate rapport with a person he had just met who suggested "you may have had the kind of experience that I had after my accident." Often the topic was introduced by talking about

books or other literature about NDEs. The other person's introduction of the subject seemed to suggest an openness or willingness to listen.

> The idea was exposed and I felt free to talk about it. (B)
>
> One of the first people I told...was because she was talking about near death experiences. (C)
>
> Any time I'm offered to tell, I try to tell. (E)

Using Humor. Only two subjects talked about humor, but both felt it helped to diffuse tension. However, one experient was only receptive to humor from another NDEr, and was very sensitive to humor from a non-experient, which could be construed as ridicule. The second subject appreciated humor, from a non-experient, because it conveyed a knowledge of the NDE characteristics and did not reflect any skepticism of the experient or event.

> It breaks the intensity of it....Because its such an emotionally overwhelming experience that the humor helps to--I can't think of the word. Maybe...diminish some of the emotional intensity. (G)
>
> There's a rabbi...he came in. He's like a comedian. He said "Well, they wouldn't let you in would they?"....He was very funny. I started talking to him...he immediately knew exactly what I was talking about. A little levity makes a lot of difference. It helps a lot. (H)

Offering Information. Offering information was emphasized by all eight informants as a very helpful and highly recommended action. Similar to introducing the subject, giving information was a way to facilitate further

communication. It also helped to normalize the experience by conveying that it was a known phenomenon that had a name, and that other people had also encountered such things. Information helped assure experients that they were not different or crazy. One of the steps in the communication process was seeking knowledge and offering information helped meet the needs of the experients.

> She said "Do you have literature to read?"....and she gave me a newsletter and some things to read. (A)
>
> First she let me read the book and then I felt...then I can talk about it too. (B)
>
> I got a lot of the education from [them]. It was like they was understanding what happened to me, you know. (D)
>
> She gave me some information that helped me. (F)

Sharing Experiences. Hearing other people tell about their own NDEs was a real thrill to experients, especially if they had not yet been given information about the phenomenon. It made it easier for most subjects to freely talk about their experiences and again provided assurance that the individual was not different or abnormal. Sharing experience was not restricted to NDErs only. Subjects found it helpful if a non-experient indicated they knew about NDEs or knew someone who had an NDE and shared what they knew of that experience. A few even found comfort when the nurse or doctor were perceived to have heard such accounts from other

patients before, even when the health care professional did not offer any feedback or information.

> I found that she had had two out of body experiences. ...Anyway that was the beginning of a very close relationship. (A)

> We cry and we laugh and we share. (G)

> I was listening to other people....all kinds of people and they had some interesting stories. After they were talking they began to ask me what happened. (H)

Actions That Were Not Helpful

Actions that were not helpful tended to cut off experients' attempts to relate the NDE or to inhibit further communication. Actions in this group did not meet the needs of the speaker and included ignoring, discounting, denying information, and medicating.

Ignoring. This action involved cutting the NDEr off before disclosure was completed. Listeners often changed the subject, failed to comment, or began busying themselves with other things. Health care professionals often got "really busy with doing...a physical exam", writing in the chart, checking the intravenous line, or adjusting medical equipment. In these instances, experients perceived the person didn't care or wasn't interested. One man stated that he felt as if he "had not really been heard". The subjects often felt disappointment, frustration, or that they were wasting time with that individual. In any event, ignoring blocked further communication.

> She really didn't care to hear about it. (B)
>
> He wasn't curious to find out more and so I just let it go. (D)
>
> ...ignored it, brushed it off....like I know, or something like that or just go on to another subject. Nobody ever focused or really heard me. (F)

Discounting. Discounting was any statement or attitude that was used to "explain away" what had happened as being something other than an NDE such as a dream or the effects of medications. One woman explained that she tested people, and "if they tried to explain it away or smooth it over, you knew they weren't receptive to hearing about it." Discounting stopped communication and tended to cause anger, frustration, or a loss of respect for the discounter.

> Some of them would try to make explanations for what happened...like I had imagined it or something...but they weren't giving me any medication at the time. (A)
>
> They wrote it off as the drugs [given to patients] or....they would discount what happened. (G)
>
> He discounted it as being a dream....and that was the end of it. (G)

Denying Information. Denying information related to withholding facts about the patient's medical condition or the events that occurred while the person was experiencing the NDE. All but one of the subjects had watched what was happening from a vantage point outside their physical bodies, and had seen others working to resuscitate them. They described many details about what the people at the scene

said and did. Experients also described seeing health care workers who were watching resuscitative efforts but who were actually outside the patient's room and behind a wall. One man asked a nurse who he knew had been present to tell him what had happened. Her refusal to tell him created conflict and prevented further communication. Experients knew something had happened and mistrusted anyone who denied it.

> I felt that everyone is not interested to tell me what happened, which is something they know for sure that happened and if they are not willing to tell me what happened, I'm not interested to tell them what happened to me. (B)

Medicating. The NDEr speaking of things that occurred during the event, was often seen by health care professionals as anxious and was sometimes medicated. To the NDEr, this action demonstrated refusal to hear or listen to what the experient had to say, and was seen to be negative. In one case it resulted in addiction to the medication.

> He said I was just getting anxious or something....so I was put on....Serax....I didn't want to take anything. (A)

> [They] medicated me or tried to. I assume it was a tranquilizer or downer or something....I had no rights at the time, by them. (E)

Self-Help Actions

Individual needs motivated people to create ways to help themselves deal with what happened to them. Subjects revealed such actions as talking into a tape recorder and

describing the whole experience, writing an account of the NDE, and attempting to draw or have someone draw what was seen during the experience. Verifying the medical version of what happened was also helpful, as well as reading literature on NDEs. Finally, starting or attending a support group was another key self-help action (Table 5).

Table 5

Self-Help Actions

Subject	Comment
A:	I needed to tell somebody so badly....I borrowed a tape recorder and talked to the tape recorder for a couple of hours. And I put the tape away. So that relieved a lot, but I still wanted [to tell somebody]. We got together and started a support group. I became the founder and leader of the local group.
B:	I got the hospital records, the first thing I tried to look what happened....I wanted to rule out for sure so when...I talk...I can tell...there is proof about it.
C:	I've really kind of within the last year devoted myself to learning more about it. I'm buying books and [am] not quite to the point where I'll attend a seminar yet, but I'm getting there.
E:	My sister was a fair artist....I bought her a lot of stuff to try to draw some of the things I'd seen. I hired a couple of people that worked for me then to try to write down what I'd seen, what I told them.
F:	I've read some of the books. I also went to that support group.
G:	I went to the local support group and I read a lot too.

Recommended Actions

All of the helpful actions discussed earlier were recommended as ways of helping other NDErs. Additionally, experients recommended orienting the NDEr to what had happened to them, for example, saying "You had a cardiac arrest" or "You were without oxygen for awhile." Next they advised asking questions such as "Can you tell me about what you experienced?", "Do you want to talk about what happened?", or "Do you remember anything about your surgery?" A third recommendation was referring the NDEr to a specialist or counselor who was knowledgeable about the phenomenon. If counseling is not available, then providing the opportunity to talk to another NDEr was highly recommended. One man suggested that hospitals hire a consultant trained to help NDErs or simply "involving [NDErs] in hospitals more." Another experient said it would have been helpful if someone had told her "There are going to be after affects, and here's what they may be. Here's what other people have experienced [after their NDEs]".

Invariably, when asked what they recommended to help other patients who might have an NDE, experients expressed the need to educate health care professionals, or anyone who deals with patients, about the near-death phenomenon including its characteristics and common experiences. In addition, some subjects felt strongly that health care

professionals should talk to an experient, either on a one-to-one basis, through a class lecture, or in seminars, to provide the opportunity for discussion and clarification that may not be available through reading materials.

Subjects also recommended more research about NDEs. Topics for research included examining NDEs in ethnic groups and exploring what changes occur in experient's lives as a result of the NDE. According to one subject, in reference to research into the near-death phenomenon, "the surface has just barely been scratched."

Impact

The latter part of the second research question focused on the effects of interventions. The impacts of actions referred to what the experient felt or did as a result of a given action or behavior. The third research question asked about the impact of the NDE itself. Only the impacts of actions will be presented. The lengthy interviews provided rich descriptions of the NDE impacts and yielded such a myriad of effects that it is beyond the scope of this presentation to include the impacts of the NDE. Data bits pertaining to impacts of actions were placed into positive and negative groupings. These impacts were determinants of future communication. Positive and negative impacts are summarized in Table 6.

Positive Impacts of Actions

Positive impacts were defined as results that indicated experients were comforted, relieved, encouraged to talk further about the NDE, or gained knowledge about the phenomenon. Experients demonstrated a decrease in their inner turmoil and indicated they felt more resolved about what they had experienced. These changes were stated as results of particular actions. Positive impacts included reassurance, promotion of disclosure, enhancement of understanding, validation, and integration.

Reassurance. Impacts in this group involved comfort and relief of anxiety or self-doubt. Patients came to realize that they were not alone in experiencing an NDE. They were reassured that they were not different or crazy. Reassurance usually came when others listened and accepted the NDE, as

Table 6

Summary of Positive and Negative Impacts of Actions

Positive Impacts	Negative Impacts
Reassurance	Isolation
Promotion of Disclosure	Rejection
Enhancement of Understanding	Self-Doubt
Validation	Pendency
Integration	Insulation
	Protraction of Resolution

well as from reading literature and sharing experiences with other NDErs.

> It made me feel not quite so weird, not quite so different. (C)
>
> That just made me think I wasn't going nuts or crazy. (D)
>
> ...and so that let me know it was okay...even if it seemed strange. (F)
>
> She indicated she'd heard other patients say things like that, so that was okay. (H)

Promotion of Disclosure. Several actions resulted in experients feeling more comfortable talking about the experience, encouraged disclosure of more details of the NDE, and reduced feelings of isolation. Listening relieved some of the tension of "holding it all inside". After being cut off several times, experients felt it was a major step just to get through the first sentence and to tell as much as they could. One subject indicated that it "gave [her] a little courage to try to tell the head nurse" after one person first listened to the edited version of the NDE. Experients also noted that actions which encouraged them to recount the NDE helped to dispel the feeling that the NDE was a secret to be hidden. It was inferred that being able to talk about the NDE reduced experients' feelings of isolation. One man related that being able to talk freely about his NDE "felt great" and that it was wonderful to finally share it with another person.

> That gave me a little courage to try to tell the head nurse. (A)
>
> ...then I felt it is published...I can talk about it too. It is no longer privileged information. (B)
>
> It was a relief to talk about it....I remember that as being probably the only time I've had a positive experience for myself as well as for her. (C)

Enhancement of Understanding. This impact focused on experients' education about NDEs. They gained information about the phenomenon, came to recognize that it was something that had a name, and learned what things other NDErs experienced.

> The biggest turning point was when I found the Reader's Digest article...it named it so then I could speak in proper terms. (A)
>
> I finally knew what it was that had happened to me. (F)

Validation. This impact indicated an increase in experients' confidence of the normalcy and reality of their NDE. Experients felt there was confirmation of their experiences either through seeing their medical records of the time the NDE occurred, being told by a knowledgeable person or other experient about NDEs, or reading about the phenomenon. Confirmation was very healing in that experients often felt that finally someone else really understood what they had experienced. Validation was most effective between experients, but was nearly as effective if the non-NDEr was very knowledgeable about NDEs.

> From then on I felt like, no, I was right all along....this was confirmation that I wasn't crazy or hallucinating. (A)

> I can't tell you the **profound** effect it had on me that someone I know had had the same experience! It was just amazing to hear my story come out of someone else's mouth. (C)

> Validation is how I felt! I felt it validated my experiences. (G)

Integration. Impacts that indicated experients had accepted, become comfortable with, and found meaning in the NDE were placed into this group. Most subjects indicated they stopped trying to deny or repress the NDE, but rather accepted what had happened after gaining information about the phenomenon. Sharing experiences and reading about NDEs were instrumental in helping experients "come to terms" with what had happened and guided some to take further actions, such as volunteer counselling for terminal patients and their families or public speaking to educate others about NDEs. Listening, showing interest, and acceptance helped experients become comfortable with disclosure and resulted in NDErs being able to share the experience to help others. One subject stated he "felt it very comforting that [others] were able to find something worthwhile in it". Subjects emphasized that they came to realize that the NDE was part of who they were.

> I started to think why...and I felt there's a reason for being here. And I accepted that. (B)

> It's hard to work your way through this. I've kind of done it...most of it has been subconscious. But, one morning I woke up and I just realized "I almost died!" My entire life changed that day...I accepted it. My entire outlook on life changed as a result of working through this...I was just real happy. (C)

> My experience was brief but it helped me after I talked to others to be able to accept more things and help people deal with dying in their own ways. (F)

> Certain things have stayed with me. All of a sudden I would get information and it would be right....I used to be more shy....but I think certain things are vitally important and have to be done...to help other people. That's what I'm doing now [with my work].

Negative Impacts

Negative impacts were defined as those where experients felt distress, confusion, frustration, or the need to deny or repress the NDE. Experients indicated that some actions prolonged the time it took for them to come to terms with the NDE. Negative impacts included isolation, rejection, self-doubt, pendency, insulation, and protraction of resolution.

Isolation. When disclosure was prevented or rejected, some experients seemed to feel almost desperate to find someone to talk to about the NDE. For most subjects, there was a period of several years before full disclosure occurred. Nearly all subjects spoke of the pain of not being able to find someone to share the NDE with.

> You have to realize, not being able to find other people to talk to about it can be very painful and very disturbing. All I wanted to do was share the information and the fact that I couldn't find anybody to share it with bothered me a lot. (A)

> I couldn't find someone to share with who wouldn't laugh at me. (B)
>
> I was thrown back [from NDE]...thrust back into [this physical world]...and had nobody to be able to talk to about it. (G)
>
> Nobody seemed to hear or pay attention to what I said about it. (F)

Rejection. When the anticipated response was opposite of what was expected and desired, it often left the experient feeling disappointed, frustrated, or disillusioned. In some cases the experient was crestfallen that a key person failed to provide the support, understanding, or enthusiasm that was expected. Other experients inferred a rejection and challenge of their personal beliefs.

> I was **crushed** to say the least. I was really depending on him and when he cut me off I was just crushed. That was a definite set-back. It took a little while to gather my courage to talk to somebody else. (A)
>
> I try not to go and open doors to tell....they get slammed in my face. (E)
>
> I went to the church people...To me this is truth and...I was expecting that they would want to hear this, but I found a closed door....They said you have to be straight from hell to be saying such a thing. (E)
>
> There have been people who are like "Oh, so you think you're an authority on this sort of thing now." (G)

Self-Doubt. Despite the fact that they "knew [the NDE] was real" and it remained vividly in their minds, some subjects began to wonder how everybody else, including doctors and learned people who discounted the NDE, could all be wrong. They began to question themselves. This self-

doubt lasted until the individuals learned more about the NDE phenomenon.

> All these learned people, you know, doctors and medical people mainly. I kept thinking that since they didn't know of this that there must be something wrong with me...so I wondered if maybe I was sort of getting warped....I spent too many years trying to discredit myself that it actually happened. I tried to explain it in every way I could think of. (A)

> ...so you try to repress it...to convince yourself after a while that it didn't happen. (C)

> I believed that there's something wrong with me. (D)

Pendency. Some actions caused the experient to suspend or defer further disclosure of the NDE until a later time. This was a temporary hold that varied in length from days to years during which time the NDE was not discussed. It could occur at several stages in the communication process, and some subjects were "on hold" about it with one person, while they were readily able to discuss it with someone else. This impact occurred most often because the listener was unable to handle talking about it rather than the experients having difficulty. Disclosure was often tabled for indefinite amounts of time until NDErs felt it was okay or necessary to talk about it again. Some subjects described still being unresolved on this issue with family, friends, or co-workers.

> ...so I really refuse to talk about it after that for a good long time. (B)

> None of them were very amenable to hearing about it so I just didn't talk about it anymore. I tabled it. (C)

> Then I just...pretty well quieted down about it until I come down here. (D)
>
> It was sloughed off...so I felt it's not worth saying...I just dropped it. (F)
>
> I just kind of clammed up about it...until a few years later. (G)

Insulation. After the initial attempts at disclosure were unsuccessful, experients began to prepare for rejection. They changed from being uninhibited to being guarded. This impact related directly to the communication process as it resulted in editing or limited disclosure and initiated testing for responses.

> I had started preparing myself to be a little stronger and getting their response and so I was sort of protected a little bit. (A)
>
> Because I wasn't able to talk to my family about it, I didn't venture to talk to anyone else about it. So I think that saved me some problems. (C)

Protraction of Resolution. Some actions resulted in a drawn out or prolonged period of time for experients to come to terms with the NDE. Basically the impact of discounting, doubting, and refusing to allow NDErs to talk freely, was that experients did not resolve their own feelings or accept what had happened. One subject "was trying to repress [the NDE]" and ended up having frequent dreams about it. She felt her life had been on hold and unhappy until she finally "came to grips" with her NDE and the after effects.

> No one even wanted to hear about it...as hard as I tried to make myself quit thinking about it I just couldn't.

> See it was there and I kept trying to put it to rest....After I read that article, and later talked to [another experient] I finally accepted that was what had happened...but that wasn't until about ten or twelve years after the experience. (A)
>
> I would have come to grips a lot sooner if they had acted like they cared and allowed me to talk about it....I felt like I had unfinished business. (C)

Summary

Eight adult NDErs were interviewed for this study. They had all experienced a minimum of three of the NDE characteristics outlined in Chapter II, and one subject had encountered all of the elements. A communication process emerged as central to disclosure of the NDE. Perceptions were an integral part of communication. Most NDErs followed a similar communication pattern, which went from affective to cognitive perspectives and involved decision windows at various stages throughout the process. Actions of health care workers, family, and friends, and the impacts of actions were also identified. Helpful actions were ones that facilitated disclosure and helped experients accept and understand the phenomenon. Actions that were not helpful tended to inhibit communication and caused frustration, self-doubt, or difficulty in accepting the NDE.

CHAPTER FIVE

CONCLUSIONS

This chapter discusses the findings of the study in relation to the conceptual framework and the review of literature. Implications for nursing practice and recommendations for future research are also addressed.

Discussion and Relationship to the Conceptual Orientation

The study framework was guided by two primary concepts, interaction, consisting of perceptions and communication, and intervention, consisting of actions and impact. The data showed evidence that these concepts were an important part of what happened to near-death experients following their NDEs as they tried to integrate it into their lives. All of the original concepts were essential to assimilation and management of an NDE, but a dynamic communication process was identified as the most important part of what experients described occurring after their NDEs. Perceptions were germane to the communication process, woven into every stage of it and influencing communication in numerous ways. Actions was the second focus identified in the data. Impacts were integral to actions.

The conceptual framework focused on perceptions of responses as a primary factor influencing interactions. The data showed that perceptions of the NDE, preconceived

expectations, and perceptions of responses operated simultaneously and continually guided experients through the communication process. Perception of the NDE and preconceived expectations were inherent prefaces to disclosure and perception of responses. All eight subjects expressed highly positive perceptions of the NDE as a compelling force motivating their urgency and need to talk about the NDE. Preconceived expectations were decisive determinants of who to tell or who not to tell, and led some subjects to delay disclosure. This factor was also a major influence on assessing the value of other's responses. Perception of responses began immediately as disclosure was occurring. It was described in the interviews as a powerful determinant of further communication. The data supported King's (1989) assertion that knowledge of perception is essential for nurses to understand patients' points of view and to facilitate care planning to meet patients' needs.

Automatic reactions often inhibited disclosure and precluded the opportunity for deliberative actions. The data suggests however, that even after an experient had a negative exchange, a knowledgeable nurse with good communication skills could still intervene, draw the experient out, and implement positive actions. The results suggest that the key may be recognition and knowledge of the NDE phenomenon, empathy to the experient's perspective and attempts to talk about the

NDE, and communication of interest, caring, understanding, and ways to assimilate the NDE. Nearly all deliberate actions were directed toward helping the person to disclose, understand, explore, and integrate the NDE, all of which were very helpful. These actions were often carried out by family or friends, since most of the experients did not talk about their NDEs to health care professionals. Negative actions all tended to repress or minimize the experience. The impact was isolation, frustration, difficult adjustment, and inhibited communication. Included in this was the attempt by health care professionals to medicate or sedate two of the experients, an action that was resented, and resulted in addiction in one patient. To meet the patient's needs, which is the goal of professional actions, the focus must be on helping the experient to accept and assimilate the NDE.

The conceptual orientation presented evaluation of impact as an essential step following any deliberative action. The data suggested that health care professionals were often unaware of the impacts of their actions. There was an inferred preconceived expectation among the experients that health care professionals should "do the right thing" about all of the events happening to their patients, including the NDE, and be concerned about the results of what was done. Being too busy, focusing on physical conditions, minimizing

or discounting, and lack of knowledge were the major impediments to positive communication.

Communication appeared in the data as something that was much more complex than the component by which information was exchanged (King, 1981). The communication process became the core of the framework to analyze and describe data results. Perceptions were evidenced as parts of communication and were inextricable from the total communication process. The conceptual orientation placed an emphasis on the value of non-verbal behaviors and cues that accompany verbal communication, indicating that non-verbal behavior accounts for 80% of all communication (Lamar, 1985). This was supported during the interviews, as experients expressed most of their perceptions based on the more subtle non-verbal communication. It was sometimes difficult to identify the specific non-verbal cues, but it was clear that the nonverbal messages were received, interpreted, trusted, and used to determine the direction that further communication would go. This suggests that a form of communication is continually operating just below the level of conscious awareness. Verbal communication was more easily interpreted and usually consistent with the face value of the statement. Experients were very sensitive to both verbal and non-verbal communication and desired encouragement to continue disclosure of the NDE. Without such encouragement, the disclosure was often incomplete, providing only general high

points of the NDE. Experients expressed the importance of conveying interest, concern, and openness to facilitate communication and lead to successful management of the NDE.

Actions, a component identified in the conceptual framework, emerged as another important concept. Impacts were closely associated with actions and were determinants of further communication.

Discussion and Relationship to the Review of Literature

The experiences of the eight subjects interviewed were consistent with the characteristics described in the literature (Moody, 1975; Ring, 1984; Sabom, 1982). Individual variations on the general characteristics add richness to the data base. Several of the experiences related by the study subjects broadened the descriptions of the elements. For example, one man described a negative portion of an NDE, which is fairly rare. He also gave an absorbing description of meeting the Supreme Being. One subject saw the tunnel but "knew" that entering it would mean she could not return. Typically, NDErs in the literature enter the tunnel and encounter the barrier at the other end of the tunnel. Another subject's description of seeing the hospital room, normal size but "10,000 miles away", while being with his deceased relatives was also unique. Additionally, some subjects had less complex NDEs that included going out of the body, and

explained that they assumed health care professionals knew all about it and that everyone experienced the same thing. There was a greater emphasis from these subjects than seen in the literature, that the experience was "so natural".

The length of time until full disclosure occurred, from six weeks to twelve years among study subjects, was consistent with previous literature. It is noteworthy that only one of the eight subjects made several attempts to talk to health care professionals about the NDE and was not allowed to describe the details to any of them. Four subjects made subtle attempts, such as "I think I was dead", "what happened last night", "I felt detached from my body", and "did you see anyone come in my room last night?". The health care professionals to whom they were speaking either did not pick up on this, ignored it, or were too busy to talk further. Consequently, the NDE was never disclosed to the providers. Three subjects made no attempt to talk to the health care providers because "I didn't know it was unusual", "it was too personal; I just couldn't talk about it or explain it", and "I was ashamed of what had happened [leading up to the NDE]". Overall, none of the eight subjects ever disclosed the full details of the NDE to their caretakers, and only one had disclosed "the high points". This is supported in the literature in which health care professionals were reported to be unaware of the phenomenon occurring to their patients

(Sabom, 1982) and to block disclosure because of their ignorance of the phenomenon (Morse, 1990; Ring, 1980). The lack of understanding by health care professionals is perhaps more understandable for the four that occurred prior to 1980 before some of the major scientific studies and recommended interventions for NDErs had been reported. Of the four that occurred since 1980, there was only one subject, who's NDE was in 1982, who had a tremendously positive experience in that other people seemed to be aware of the phenomenon and willing to discuss it. However, none of those individuals were the health care professionals who cared for him daily during a lengthy hospital stay. The ease with which this individual assimilated the experience is suggestive of the benefit of positive actions that prevent NDErs from having to deal with the experience on their own. The most recent NDE in this study occurred in 1987 and was met with no apparent knowledge of the phenomenon by health care professionals, family, or friends. The sample size is too small to make broad generalizations, but this finding suggests that education and awareness of NDEs among health care professionals is not yet sufficient to meet the needs of the patients.

The subjects' difficulty in broaching the topic of the NDE, dying, and the resulting spiritual beliefs is consistent with the social taboos of talking about these topics (Drake, 1988; Kubler-Ross, 1969; Morse, 1990). Additionally, fear of

being ridiculed or thought crazy deterred disclosure in these eight subjects, a pattern suggested in much of the previous literature (Dougherty, 1990; Serdahely et al., 1988). There was however a trend among the NDErs interviewed to be more open about the NDE as more people around them became aware of the phenomenon. Among some, it was a tentative attitude, easily squelched by disbelief or argumentative responses, but shows a positive trend from the impact of disseminating information regarding NDEs. The NDErs desire for validation, assurance, and understanding from the medical profession and significant others was also consistent with previous literature (Morse, 1990; Oakes, 1981; Ring, 1984). Additionally, some of the subjects expressed an interest in having NDErs involved in hospital programs to help new experients, and having more active input and activity in educational programs for health care professionals.

The current literature provides guidelines for interventions to help NDErs, but no literature was found which evaluated the effectiveness of interventions. This study provides initial explication of the impacts of the recommended interventions. Just listening is one of the first interventions recommended by IANDS (1984) and in other nursing literature (Corcoran, 1988; Papowitz, 1986). In this study, listening was the most frequently mentioned intervention and all eight subjects indicated it was helpful. Several also

expressed the frustration and isolation that resulted when others refused to listen.

Interventions that convey acceptance, reassurance, and validation were also recommended in the literature (Corcoran, 1988; IANDS, 1984; Papowitz, 1986) and were supported in this study. Corcoran (1988) advised avoiding labels or implying that the NDE could be explained in physical or psychological terms. Informants verified that such actions were an immediate block to further communication and relayed the degree to which such actions caused self-doubt or delayed resolution concerning the NDE. Subjects stated that their self-doubt and repression of the NDE took an emotional toll that lasted until they gained knowledge about the phenomenon and accepted the NDE. Reassurance that the NDEr was not "crazy" and validation that others experienced NDEs were also mentioned by the study subjects as helpful actions recommended for new NDErs. Serdahely et al. (1988) implied that validation includes recognizing that the NDE is meaningful to the experient. They cautioned nurses not to minimize the personal impact of an NDE. Study subjects identified instances where the NDE was not taken seriously or was minimized and related the negative impact of such action. These findings were consistent with the problems Papowitz (1986) noted among NDErs she counseled.

Lee (1978) and Oakes (1981) recommended the actions that provide the experient with information and the opportunity to talk about the NDE. First they recommended asking if the NDEr wants to talk about what happened. In addition they advised orienting the person to time and place, and of their general medical status following resuscitation. Another recommendation was being open and honest, using plain terms, about the medical circumstances that occurred. All of these interventions were suggested by several of the study subjects when asked what they would have liked to have been done for them. When orientation was not provided it created conflict and distrust between the experient and the health care professionals and prevented disclosure of the NDE.

Interventions providing the opportunity to talk about the NDE also included referral for counseling if necessary. Corcoran (1988) included the option to refer patients to an appropriate professional or counselor but advised ensuring that it was someone who understood the phenomenon. Study subjects indicated talking with clergy or other health care professionals who were not aware of NDEs had blocked disclosure. One man had talked with a rabbi who was extremely knowledgeable and accepting of NDEs. The subject indicated this was a very positive experience that made talking about the NDE easy. Two subjects did have the opportunity later to speak with a death and dying counselor who was very

knowledgeable about NDEs and relayed that this not only helped them accept what had happened but enabled them to use their experiences to help others.

Self-help actions initiated by study subjects confirmed the positive impact of other interventions recommended in the literature. One individual attempted to have an artist draw what he had seen. This is a variation of having the experient draw pictures as part of the therapy to draw out an experient or help them make sense of what occurred (Strom-Paikin, 1986). Two other self-help actions described by study subjects were new ideas devised by the experients. These were talking into a tape recorder and writing down the experience. These actions might be especially helpful with patients who are reluctant to talk about the NDE to others. By recreating the experience, these actions may foster personal acceptance of the NDE and help NDErs come to terms with what they experienced.

Finally, the literature suggests patients may want to talk with other experients (IANDS, 1984). The majority of study subjects became very animated in telling of the first time they spoke to another NDEr and related that it had a "profound effect" on them. Communication was easier with someone who had experienced a similar event and it provided confirmation as well as the feeling that they were "truly understood". Thus this study showed a positive evaluation of

the recommended interventions, outlined the communication process, and provided a rich description of the perceptions from the experients perspective. The study also detailed negative communication, perceptions, and actions and their impacts on the experient which has only been alluded to in the literature through incidental findings and anecdotal accounts of individual patients.

All eight subjects described the NDE as a positive event that they were glad had happened to them. They indicated that the NDE was an integral part of their lives which affected their communication with others, their beliefs, and their lifestyles. This finding supports Dougherty's (1990) assertion that the NDE is a positive event that initiates a growth process for NDErs.

One common thread that became noticeable during some of the interviews was the tendency for some experiencers to speak in terms that indicated a separateness from non-experiencers. Four of the eight subjects made references to "you people" indicating non-NDErs. Examples of such phrases were "you people talk about love but it is nothing like that love [experienced during the NDE]", "you people worry about material things", and "what you people call the other side". This not only indicates that the NDErs feel a separateness from non-NDErs, but in the interviews it seemed to suggest an identification with the "other realm" they had experienced

during their NDEs. This has not been described in the literature, but was a strong commonality in this study.

Another incidental finding that raised questions that have not been addressed in previous literature related to recurrent out-of-body experiences. The NDE was a single event for two study subjects. Five subjects had additional out-of-body experiences prior to or following their NDEs. The eighth person had two NDEs three years apart. Of those who had out-of-body experiences, two had them on several occasions in childhood, one of whom continued to have them as an adult, "about once a month", both prior to and after her NDE. Two other subjects had a single out-of-body experience in adulthood a few years prior to the NDE. The fifth subject had frequent out-of-body experiences that began only after her NDE. The two subjects who have the numerous out-of-body experiences described them as occurring suddenly and stated they were sometimes frightened at the lack of control. They have both worked on learning to exert some control over this experience. The interview guide did not include a question concerning the occurrence of such events, but they were a common thread that was mentioned incidentally by the subjects. In the current literature, one source described a man who began going out of his body "unexpectedly and uncontrollably" so often that it had become a problem (Atwater, 1988, p. 90). Atwater (1988) implied that this may occur in many NDErs. It

is unclear what may cause these unsolicited experiences, but it merits further attention.

Implications for Nursing Practice

As technology advances and resuscitative measures become more aggressive, it is necessary for health care professionals to become aware of the increasing number of NDEs and that NDEs are not events that are limited to cardiac arrests or multiple trauma victims. Subjects in this study reported NDEs during routine surgery, near-drowning, drug overdose, motor vehicle accident resulting in severe head injury, illness (Guillian-Barre Syndrome), miscarriage with hemorrhaging, and cardiac arrest. Essentially all patients are potential experients and nurses in all specialties need to be aware of the NDE phenomenon.

The primary implication is that education about NDEs should be implemented as a basic part of undergraduate study, and practicing nurses need to receive education through seminars, workshops, inservices, and journal articles on NDEs. There is a need to disseminate knowledge of the characteristics of the phenomenon, the appropriate interventions, and the possible after-affects for experients.

Study subjects indicated that nurses seemed more approachable and were more likely to be selected for disclosure than physicians. Nurses need to be alert to medical circumstances and patient behaviors that may indicate

that an NDE has occurred. Professionals must also be cognizant of appearing too busy to listen, either to the patient or family. A rapport with the family is an important part of care, since the experient may first confide in a trusted family member who may seek advice from a nurse who is perceived as open, caring, and interested. Patient teaching should involve family and significant others.

Additionally, the data in this study emphasizes the importance of communication skills. Patients begin forming perceptions of health care providers from their initial contact, and these perceptions can determine how much the patient will confide in each individual caregiver. The nonverbal behaviors and cues, which are almost automatic or just below the level of conscious awareness, were the first indicators study subjects used in their perceptions and were trusted as more accurate than verbal messages. Nurses need to examine their verbal and non-verbal communication on an individual and personal basis and place importance on maximizing their interpersonal skills.

The NDE is very real to the experient. It is not important what the professional believes personally. Deliberative nursing actions require meeting the **patient's** needs. Nurses should listen and allow the patient to talk freely even if they are personally skeptical about NDEs. If a nurse is unable to accept or listen to an account of an NDE,

then it is essential to find another professional who is knowledgeable and can help the NDEr.

It is also important to be sensitive to the frustration and difficulty experients have in describing the NDE. Subjects expressed that no matter how they tried to explain it, they knew non-NDErs could not fully understand. Listeners should avoid assurances such as "I know what you're feeling". One NDEr's advice "Know that you don't know" summarizes the caution that should be kept in mind while providing comfort.

Recommendations for Further Research

This study suggests a dynamic communication process that needs to be more fully explored in studies of NDE's in subjects of various ethnic groups, cultures, ages, and religions, as well as with other types of emotionally charged experiences. This was a cross-sectional study involving many NDEs that occurred prior to or during the period of scientific investigation of NDEs and publication of recommended interventions. An intervention study with subjects whose NDEs occurred more recently and who received knowledgeable care concerning the NDE is suggested to test the steps of the communication process following an NDE and to see if it is changed when NDErs receive positive interventions immediately following their NDE.

Further evaluation of the interventions should be done through additional research, with more NDErs who have told

their caregivers about the NDE. It would also be helpful to focus on health care professionals and the reasons they are unaware of NDEs in their patients. A paired study that compared patients' perceptions to the perceptions of the nurses caring for the NDErs would help explicate the intricacies of the communication process and provide a better understanding of the interactions and perceptions.

The two incidental findings of this study warrant further consideration. Additional studies might explore the occurrence of multiple out-of-body experiences both before and after NDEs. It would also be interesting to investigate if the NDErs attitude of being separate from non-NDErs prevails in future studies.

Finally, the wealth and complexity of data that emerged concerning the impact of the NDE, along with the study subjects' recommendations indicates the need for additional research into the after-effects of NDEs on experients and life changes that occur as a result of the NDE.

Summary

All of the original concepts in the conceptual orientation were explored in the data analysis, but the framework was reorganized with the communication process as the core of the experience and perceptions were germane to the communication process. Impacts were integral to the actions. The interview data were consistent with current

literature and provided initial confirmation of the need for and effectiveness of positive interventions, as well as a rich description of the difficulties encountered during attempts to disclose the NDE to health care professionals and significant others. The major implications for nursing include the need for widespread dissemination of information about the NDE phenomenon, the awareness of the potential for NDEs in all specialties, and development of better communication skills. The NDE phenomenon presents an increasing need for exploration and has many aspects that require further research.

APPENDIX A

HUMAN SUBJECTS APPROVAL

Human Subject Committee

THE UNIVERSITY OF
ARIZONA
HEALTH SCIENCES CENTER

1690 N. Warren (Bldg. 5268)
Tucson, Arizona 85724
(602) 626-6721 or 626-7575

May 30, 1991

LaVon E. Yuill, RN
College of Nursing
Arizona Health Sciences Center

RE: NEAR-DEATH EXPERIENCES: AN EXPLORATION OF PERCEIVED RESPONSES, EFFECTS OF INTERVENTIONS, AND IMPACT

Dear Ms. Yuill:

We received your above referenced project. Regulations published by the U.S. Department of Health and Human Services [45 CFR Part 46.101(b)(3)] exempt this type of research from review by our Committee.

Consult your department chairman for approval, the requirement of a subjects' consent form and any other departmental guidelines.

Thank you for informing us of your work. If you have any questions concerning the above, please contact this office.

Sincerely yours,

William F. Denny

William F. Denny, M.D.
Chairman,
Human Subjects Committee

WFD:sj

cc: Departmental/College Review Committee

APPENDIX B

DISCLAIMER

DISCLAIMER

Near-Death Experiences: An exploration of perceived responses, effects of interventions, and impact

The purpose of this project is to help nurses gain a better understanding of the near-death experience and how to help patients who have such experiences. By responding to the tape-recorded interview you will be giving your consent to participate in the study.

There are no known risks or costs to you, other than your time for the interview. Your participation will be confidential and anonymous. Code numbers will be used to identify you, rather than your name. Tapes will be destroyed after your responses are typed.

There are no right or wrong answers to these questions. You may choose not to answer some or all of the questions, or to withdraw with no consequence whatsoever. You are free to ask questions about the study at any time. Once we have completed the interview, you may also ask any questions you have regarding the near-death experience.

Thank-you for your time and for sharing your experience. Your participation in this study is appreciated.

LaVon Yuill, RN
Graduate Student
University of Arizona
College of Nursing

APPENDIX C

DEMOGRAPHIC DATA FORM

DEMOGRAPHIC DATA FORM

1. Sex : Male_____ Female_____ Subject No._____

2. Age: _____

3. Racial-ethnic background:
White ____
Black ____
Hispanic____
Oriental____
Other ____Specify_____

4. Marital Status:
Single _____
Married _____
Remarried_____
Separated_____
Divorced _____
Widowed _____

5. Number of years of education completed_____

6 Religious preference or affiliation:
Catholic _____
Protestant_____
Jewish _____
Moslem _____
None _____
Other _____Specify_____

7. Occupation_____

8. Approximate date of NDE_____

9. Knowledge of NDEs prior to own NDE? No _____Yes_____
If yes - specify: Knew person who had NDE_____
Read about NDEs _____
Saw on TV or movie _____
Other:_____
Specify how much/which books etc.:_____
_____

10. Explored NDEs after own experience? No _____Yes_____
If yes - specify: Read about NDEs _____
Compared with other NDErs _____
Talked with non-NDEr _____
Saw on TV or movie _____
Other:_____
Specify how much/which books etc.:_____
_____

APPENDIX D

INTERVIEW GUIDE

INTERVIEW GUIDE

1. Tell me about the circumstances under which your experience occurred.
   -medical status
   -environment

2. Describe the experience you had during your (illness, arrest etc.). I am interested in as much detail as you can remember and anything that occurred, no matter how unusual, confusing, or small of a detail it may seem to you. Also, please try to tell me about what you were sensing and what you were thinking as you were experiencing this.

3. Tell me about the first time you ever told anyone about your experience and how you felt talking about it.

4. How did (the listener) seem to respond to what you told him/her about your experience?
   --What made you think the listener thought/felt that?

5. Describe the specific things, such as behaviors, cues, statements, actions, or whatever that made you decide to tell this person first.

6. Had you attempted to tell anyone else about your NDE before this, and if so describe what happened and why you decided not to talk about at that time.

7. After you first talked to the (health care professional / family member) did you tell other (health care professionals / family members)? Why or why not?

8. The first time you talked to someone about this experience it was a (health care professional / family member). Did you ever tell a (health care professional/ family member /significant other) about it also? How did they seem to respond to what you told them?

9. When you told the (doctor/nurse/clergy) describe what things they said or did that were helpful to you in dealing with this experience. Why was it helpful to you?

10. When you told the (doctor/nurse/clergy) describe what things they said or did that were not helpful to you in dealing with this experience. Why wasn't it helpful to you?

11. Tell me what you would have liked to have been done for you? What would you recommend doing for others in the same situation?

12. Describe the specific things (behaviors, cues, actions, statements) that cause you not to talk about your experience with someone.

13. Describe what your experience has meant to you in your life.
-love
-self
-relationships
-nature/universe
-attitude changes
-spirituality

14. Is there anything else you would like to add?

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